Access to Post Abortion Care (PAC) in Burkina Faso: an ethnographic study

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Abstract

In Burkina Faso, abortion is permitted only in cases of incest, rape, when the woman's life is in danger or in cases of fetal malformation. Access to safe abortion is therefore legally restricted in Burkina Faso and women often resort to unsafe abortion at great risk to their health and survival. The government has responded to this problem by implemented Post Abortion Care in public health facilities, a harm reduction strategy to prevent deaths from unsafe abortion in countries with restrictive abortion laws. However, access to post abortion Care is limited because of social and structural challenges. The aim of this study is to explore how women who have had an abortion negotiate their access to PAC in Burkina Faso using an ethnographic approach. The findings of the study show that the experience of the PAC involves several and overlapping perceptions and practices of the women, their relatives, and health care providers. These perceptions and practices are constructed by social norms, and by structural and organizational constraints regarding abortion and the provision of PAC. As a consequence, women's access to care is often delayed, and they are also often the victims of a poor quality of care, including discrimination from health care providers who are opposed to abortion. In addition, this study found that health policy on abortion is focused on obstetrics care services and reproductive health services, while the needs of women after an abortion go beyond these services. As a conclusion the study therefore highlights the need for an integrative response across health care services in the supply of PAC.

Dedication

This thesis is dedicated to my Mother, Father and all my familly for their support during my study, their prayers and their encouragement.

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List of acronyms

CRESAR: Committee of Reproductive Health Research

FP: Family Planning

HIV: Human Immunodeficiency Virus

INSD: National Institute of Statistics and Demography

ICPD: International Conference on Population and Development

IPAS: International Projects Assistance Services

JHPIEGO: Johns Hopkins Program for International Education in Gynecology and Obstetrics

MC: Medical Center

MCA: Medical Center with surgical Antenna

MHOB: Ministry of Health of Burkina Faso

MVA: Manual Vacuum Aspiration

PAC: Post Abortion Care

PHC: Primary Health Care

PNUD: United Nations Development Programme (UNDP)

TFR: Total Fertility Rate

UNICEF: United Nations Children's Fund

UiO: University of Oslo

UO: University of Ouagadougou

USA: United States of America

USAID: U.S. Agency for International Development

WHO: World Health Organization

Chapter 1: Introduction

Complications occurring after unsafe abortion contribute to maternal mortality and morbidity in developing countries and are recognized by the international community as an important public health problem (Bertrand and Escudero, 2002). Each year, throughout the world, approximately 210 million women become pregnant and over 135 million of them deliver live born infants. The remaining 75 million pregnancies end in stillbirths, spontaneous or induced abortions (WHO, 2008). An estimated 21.6 million unsafe abortions took place worldwide in 2008, almost all in developing countries (ibid). Access to safe abortion can be restricted by the law, and this may make women turn to illegal or often unsafe abortion, or make them hesitant to seek care when urgently needed because of complications of an unsafe abortion (Singh and al; 2009). Many of these abortions end in serious complications and even death; globally, an estimated 47,000 women die every year as a result of unsafe abortions, while many more experience severe health consequences. The vast majority of these deaths occur in Sub-Saharan African countries (WHO; 2008) where the legislation on abortion is inherited from colonial powers and is still severely restrictive.

In Burkina Faso, abortion is permitted only in cases of incest, rape, when the woman's life is at risk or in cases of fetal malformation. Access to safe abortion is therefore legally restricted, and women often resort to unsafe procedures (Sedgh et al, 2011), at great risk to their health and survival. The Ministry of Health of Burkina Faso (MHOB) estimates that abortions contribute to 10% of all maternal deaths (MHOB; 2011), although measuring abortion-related maternal mortality is fraught with difficulties, as data tend to be underestimated (Ahman et al., 2000). A study conducted in the capital, Ouagadougou, shows that 30% of maternal deaths were caused by illegal abortions (Lankoande, 1999).

The question of unsafe abortion was raised during the International Conference on Population and Development (ICPD) in Cairo in 1994. The participating governments agreed that family planning services should be expanded and improved to reduce the burden of abortion; and that post-abortion care (PAC) should be provided to avoid repetitive abortion. Abortion-related death and disability can be prevented in three ways: by preventing unintended pregnancy, by providing a safe legal abortion, and by providing PAC (Gebreselassie et al, 2010). Thus, PAC packages have been implemented in many countries with restrictive abortion laws to address the complications associated with unsafe abortion (Rasch, 2011). Burkina Faso started implementing PAC in public health facilities in 1998. PAC focuses on treatment of incomplete

abortions and provision of post-abortion contraceptive services (ibid). Social, religious, policy, and legal restrictions on abortion and contraception continue to pose challenges to programs offering PAC (Maureen and Turner, 2003). However, information on this problem remains an open question in Burkina Faso, as no study has addressed the experience of getting access to PAC after an abortion.

The aim of this study is to explore how women who have had an abortion negotiate their access to PAC in Burkina Faso. Specifically, the study explores both women's and health care providers' perceptions and attitudes towards abortion and PAC, and identifies social and structural challenges that women face in accessing PAC in Burkina Faso's main university hospital.

The thesis is structured into five chapters, including the introductory chapter. Chapter two consists of a literature review on abortion and PAC. It begins by defining abortion and PAC. The consequences of abortion are also described. Emphasis is put on the origin and evolution of the concept of PAC, both globally and in Burkina Faso. It also presents literature on women's experiences of PAC services.

Chapter three presents the research design. It presents the theoretical framework of the study, and the location and the general background of the study site. The data collection methods and strategy for analysis are described in this chapter. In addition, it includes a discussion about my reflexivity as the researcher doing ethnography in a hospital setting.

Chapter four is a presentation of the findings of the study. It is divided into six main sections: 1) a case presentation; 2) the perceptions on abortion and PAC; 3) the delay in getting access to PAC and its social implications**;** 4) the management of PAC and the therapeutic relation between health care providers and women; 5) physical and equipment constraints on access to PAC and their relation to the cost of treatment; and 6) the limits of the concept of comprehensive PAC.

Chapter five provides the discussion of the findings and the conclusion of the study.

Chapter 2: Literature review

This section summarizes and synthesizes the published literature as well as policy documents on the issue of abortion and PAC.

2-1-Definition of Abortion

Abortion is the termination of pregnancy before the viability of the fetus. An abortion can occur spontaneously or it can be purposely induced (Berman et al, 1987). An induced abortion is defined as a procedure intended to terminate a suspected or known intrauterine pregnancy and to produce a nonviable fetus at any gestational age (ibid). Spontaneous abortions (sometimes called miscarriages) are those for which a termination of a pregnancy is not provoked voluntarily (Jagnayak, 2005). A spontaneous abortion is one that takes place naturally; a situation over which the mother has no control. An induced abortion is one that is brought about by medical means (Grisanti, 2000), or results from the use of herbal preparations or other traditional practices (WHO, 2008).

Induced abortion may be legal or illegal according to the law in the country. Legal abortion is any abortion carried out by a medical practitioner approved by the law of the country, who terminates a pregnancy for reasons permitted under the law; while illegal abortion means any abortion which is performed by any person who is not permitted under the relevant law of the country (ibid). Where abortion is legally restricted, women are more likely to resort to untrained providers or undergo the procedure in unsanitary and in unsafe conditions (Reed Boland and Laura Katzive, 2008).

Unsafe abortion is defined by the WHO (1992) as any procedure to terminate an unintended pregnancy, done either by people lacking the necessary skills, or in an environment that does not conform to minimum medical standards, or both. Unsafe abortions typically take place in countries with highly restrictive abortion laws. Moreover, the question of whether restrictive abortion laws prevent women from obtaining abortions comes up (Sedgh et al., 2012).

Several studies have shown an association between unsafe abortion and restrictive abortion laws. For example, a study conducted in 82 countries with highly restrictive abortion laws shows that the median rate of unsafe abortion is 23 per 1000 women in these countries compared with 2 per 1000 in countries that allow abortions (Haddad et al., 2009). Data compared across countries also show that abortion-related deaths are more frequent in

countries with more restrictive abortion laws (34 deaths per 100,000 childbirths) than in countries with less restrictive laws (1 or fewer per 100,000 childbirths) (WHO, 2003). It has been shown that when abortion is legal and when safe, accessible services have been provided, unsafe abortion disappears and abortion-related mortality and morbidity is reduced (Berer, 2004).

These definitions show that abortion is a broad concept that covers several more specified terms. Depending on the type of abortion, it can be termed spontaneous or induced. Abortion can be considered legal or illegal depending on the laws in different countries. Depending on the conditions in which it takes place, an abortion can be safe or unsafe. Because of its consequences, unsafe abortion is the subject of several articles, yet safe abortion (Sedgh et al, 2007) and spontaneous abortion may also have negative consequences (Rash, 2011).

2-2-Consequences of abortion

Unsafe abortion presents several consequences. These can be grouped together according to health consequences, economic consequences and social consequences.

The consequences of unsafe abortion vary depending on the context and the environment (Singh, 2010). Unsafe abortion mainly occurs in developing countries where abortion is highly restricted by law, and in countries where, although legally permitted, safe abortion is not easily accessible. (Grimes, Benson, 2003). According to the WHO, every 8 minutes a woman in a developing nation will die from complications related to an unsafe abortion (Haddad and Nour, 2009). It was estimated that in Africa, 14% of maternal deaths (29,000) in 2008 were due to unsafe abortion (WHO, 2011). About 1.7 million women in the region are hospitalized annually for complications from unsafe abortions (Singh, 2006). In Burkina Faso, a study in Ouagadougou in 2004 estimated 40 induced abortions per 1,000 women per year, or one abortion per woman in her lifetime, this represents 7800 clandestine abortions per year (Rossier, 2006). In addition, 60% of illegal abortions lead to complications, from which 14% require emergency treatment. In addition to these complications, hospital studies have shown that abortions were responsible for 24% to 28% of maternal deaths (Tapsoba, 1999).

The severity of the immediate consequences of unsafe abortions is related to gestational age, and to the method which is used to induce abortion. In addition, the younger and the poorer

women suffer more from the consequences of illegal abortion (Faùndes and Hardy, 1997). In general, complications of unsafe abortion include immediate consequences like hemorrhage, sepsis, peritonitis, and trauma to the cervix, vagina, and uterus (WHO, 2012). Severe complications that are less immediate can also occur from unsafe abortion. According to the WHO (2007), 3 million women suffer from the effects of reproductive tract infections, and 24 million women suffer from secondary infection, due to unsafe abortion. Morbidity due to unsafe abortions has a negative impact on women and their families, but also on the whole society, as it affects the resources of the health system, and causes a loss of productivity.

The economic impact of unsafe abortions falls into two components: direct costs and indirect costs. Direct costs include the costs related to the management of the consequences of unsafe abortions, including health personnel, medications, blood, supplies and equipment, and overnight stays. Indirect costs include the loss of productivity by women and their household members due to abortion-related morbidity and mortality and the effect on children's health and education following the death of their mother (Grimes, 2006). A study conducted in Nigeria shows that the financial cost to the women and their families of treating complications resulting from an unsafe abortion was almost four times the cost of a safe abortion provided in the hospital (Henshaw et al., 2008).

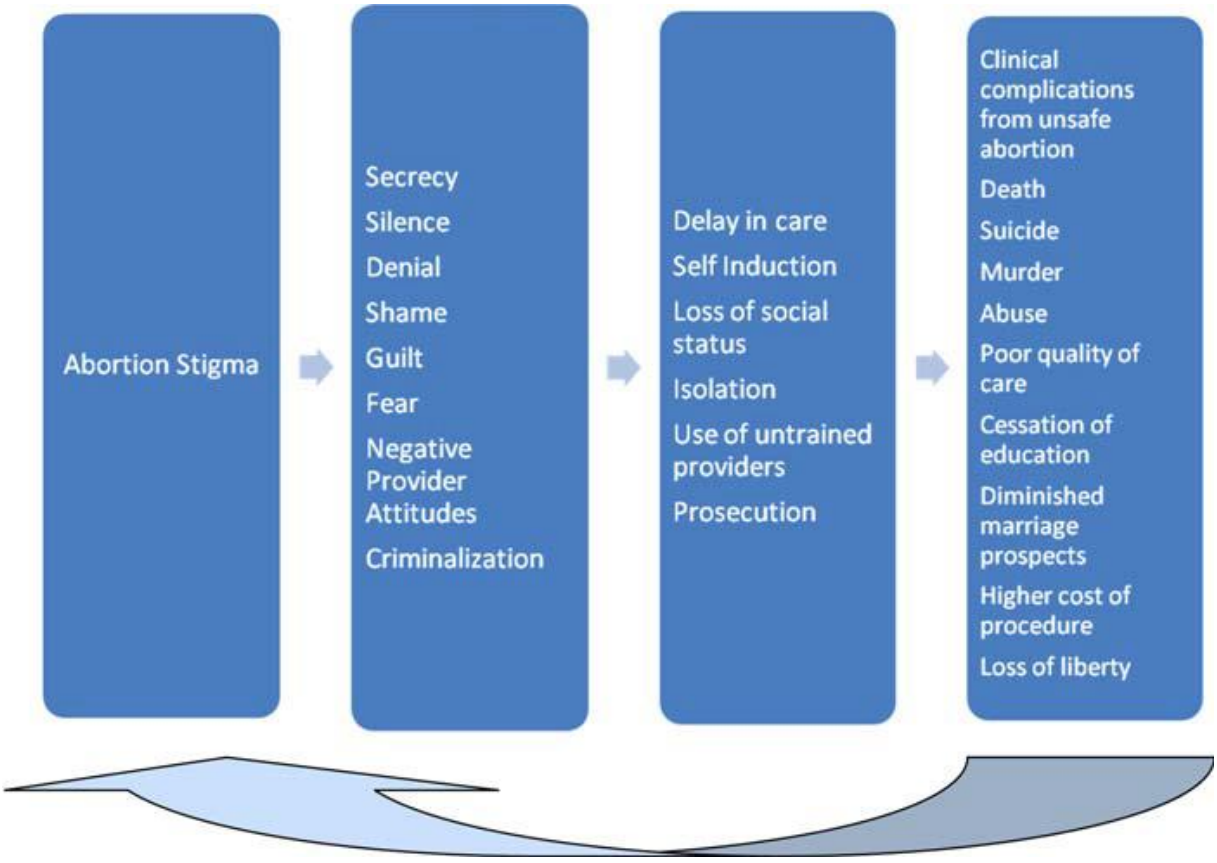
The cost of PAC can vary according to the complication and the organizational level where care is provided (Vlassof, 2006), and this cost can impact on health systems and the public sector (Singh, 2010). For example, the total cost for health systems in developing countries of treating minor post-abortion complications was estimated at $12.5 million in 2005 (ibid.). These costs are often reduced in Primary Health Care (PHC), because of subsidies in public health system and private contributions (Vlassoff, 2006). Singh (2010) supports this position. According to her, direct costs are generally highly subsidized by the public sector. In addition, hospitals typically receive the patients with the most severe complications – because lower-level facilities are unable to treat such patients, and therefore refer them. The process of seeking care can also create indirect costs, such as transport costs, which can be significant. Expenditure due to the treatment can also impoverish women and their families (Singh, 2010).

Unsafe abortion also has several social consequences. According to Singh (ibid), most of the research on the social consequences of abortion is focused on countries where abortion is legal and safe, while few studies are done in countries where abortion laws are restrictive. Yet the social consequences of abortion are considerable in these countries. Therefore, research

studies are needed to examine these possible social consequences, including the effect on the stability of marriages and quality of relationships (including intimate partner violence); the impact of a mother's ill health and/or death on the well-being of her children and family; and the impact of (social) stigma (ibid).

Stigma may determine whether a woman seeks lifesaving medical care when suffering post-abortion complications (Shellenberg et al; 2011). According to Link et al (2006), stigma can have negative effects on employment opportunities, housing, and access to medical care. Institutions may create or perpetuate abortion-related stigma through their policy, architecture and norms (Kumar et al, 2009). Thus Kumar et al (ibid) present a hypothesis of how the process of abortion stigma can lead to negative health outcomes for women.

Figure 1: Conceptual framework of relationship between stigma and unsafe abortion (source: Kumar et al. 2009)



In total, existing studies suggest that the consequences of unsafe abortion constitute a global emergency and a challenge for countries facing its effects. This requires a mobilization around the issue, so as to reduce the consequences of unsafe abortions.

2-3-The concept of PAC: origin and definition, evolution and challenges

Several international conferences have sought to justify women's access to safe abortion methods and reproductive health services as part of women's reproductive rights. According to Germain and Kim (1998), the World Population Conference held in 1974 in Bucharest recognized the right of "everyone" to decide freely on the number of children and the spacing of their births, and implicitly gave this right to women. In 1984, at the International Conference on Population in Mexico City, the dangers of abortion-related risks were highlighted, although no major decision was taken about addressing the problem. The World Conference on Women, held in Nairobi in 1985, explicitly recognized the rights of the woman to control her own fertility. The main chapters of the International Conference on Population and Development (ICPD) held in 1994 in Cairo and the International Conference on Women held in Beijing in 1996 both recognized unsafe abortions as a major public health problem, and defined health services related to abortion as an essential component of reproductive health care (Corbett and Turner, 2003). In 1996, post-abortion care was integrated into community-based family planning and reproductive health activities in many countries by WHO (Population Council, 1998).

The term "post-abortion care" (PAC) was first articulated in 1991 by International Projects... Assistance Services (IPAS). The objective of this was to integrate post abortion care and Family Planning (FP) in health systems, in order to avoid repeated unwanted pregnancies and improve women's health (ibid). In 1994, IPAS published the original PAC model, which comprised three elements: (1) emergency treatment services for complications of abortion; (2) post-abortion FP counseling and services; and (3) links between emergency abortion treatment services and comprehensive reproductive health care (ibid). In 2002, in order to expand services into PHC and the community and increase abortion-related prevention activities, the original three elements of PAC evolved to five elements. The link with the community and other reproductive health services was added to the starting model, to articulate a comprehensive service of PAC (ibid). These five elements are:

Figure 2: Elements of PAC

1-Community and service provider partnerships

- Prevent unwanted pregnancies and unsafe abortion
- Mobilize resources to help women receive appropriate and timely care for complications of abortion
- Ensure that health services reflect and meet community expectations and needs

2-Counseling

- Identify and respond to women's emotional and physical health needs and other concerns

3-Treatment

- Treat incomplete and unsafe abortions and potentially life-threatening complications

4-Family planning and contraceptive services

- Help women practice birth spacing or prevent an unwanted pregnancy

5-Reproductive and other health services

Preferably provide all appropriate health services on-site, or via referrals to other accessible facilities in provider's network

Source: Postabortion Care Consortium Community Task Force, Essential Elements of Postabortion Care: an expanded and updated model, PAC in Action, 2002, No. 2, Special Supplement. (cited by Corbett and Turner, 2003)

PAC in Burkina Faso

The introduction of PAC in Burkina Faso followed this process started by the international community and civil society organizations. Besides that, it also took national political will, and the commitment of several actors, to introduce PAC in the country.

A series of consultative meetings (ICPD 1994, Cotonou Symposium 1997, Forum of Conakry 2003, etc.) have been organized since PAC was initiated (Policy Project, 2003). An evaluation of the maternal health services of two government hospitals revealed the need to improve PAC services, and provided support for improvement in Burkina Faso (Population Council, 1998). PAC services were poor because (1) the country did not have policies and standards concerning the treatment of incomplete abortion; (2) directives relating to family planning did not refer to post abortion contraception; (3) methods for preventing infections were deficient; and (4) the technical knowledge of the staff regarding complications and follow-up post abortion was incomplete (ibid). In 1997-1998, the Population Council and Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO) collaborated with the Committee of Reproductive Health Research (CRESAR) in Burkina Faso to develop a framework of PAC (Dieng et al, 2008). PAC was introduced in Burkina Faso through operational research. This research was conducted in collaboration between JHPIEGO, the CRESAR, and the Ministry of Health, which was concerned by the considerable number of hospital deaths related to clandestine abortions (18-20%).

This participatory approach facilitated the discussions within the Ministry of Health. Promoters of PAC highlighted the discourse on the need to prevent maternal mortality, showing the quality of the services offered to patients suffering from complications of abortion. The results of the research in the two hospitals eventually sold the political authorities on the introduction of PAC (ibid). This process was facilitated by the amendment of the Criminal Code in 1996, and later by the enactment of a law in 2005, authorizing abortion in three cases: when the life or health of the woman is in danger, in the case of serious fetal malformation, and in the case of rape or incest (Boland and Katzive, 2008).

In 1995 WHO published guidelines in order to contribute to the reduction of maternal mortality and morbidity associated with abortion (Dieng et al, 2008). Between 1998 and 2005, PAC was included in the documents of policies, standards and protocols in Burkina Faso (ibid). The country adopted a centralized approach to the scale-up of PAC services, with guidance flowing from the national to sub-national levels (RamaRao et al, 2011) with support from partners like JHPIEGO and UNFPA (Dieng et al, 2008). This support was limited to regional health facilities like regional hospitals. Thus, the non-covered areas remained without activity. Facing this problem, the country has signed a partnership agreement with IPAS for

the training of health providers in some regions not yet covered and for a supply of manual vacuum aspiration kits (ibid).

A key component of PAC programs has been the introduction of Manual Vacuum Aspiration (MVA) for the treatment of incomplete abortion (Solo, 2000). MVA has become an alternative to the standard surgical curettage. Performed under local anesthesia in the setting of a treatment room, MVA is considered a cost-effective alternative, and is often used for emergency care in low-income settings (Milingos et al, 2009). However, the implementation of PAC still faces some challenges. Indeed, MVA is not widely available in many developing countries. On top of that, attention is much more focused on MVA than on counseling and the linkage with other reproductive health services. Doctor-patient relationships often exist in a climate of fear and suspicion (Hulington and Piet-Pelon, 1999). Rash's (2011) review of PAC has shown that the main barriers reported in many low income settings were government restrictions on procurement, high cost of equipment, limited access to MVA-training, and problems obtaining MVA equipment (Rash, 2011). In addition, a study conducted in Nigeria challenged the assumptions according to which MVA is considered more cost-effective than surgical curettage (Rash, 2011).

The evolution of policy responses to abortion, including the provision of PAC, has occurred within a difficult context. Significantly, many policies were dependent on funding from the U.S. Agency for International Development (USAID), whose support was in turn dependent on the political orientations of the ruling party in the United Stated of America (USA). For example, at the International Conference on Population in Mexico City in 1984, the U.S. government limited funding, denying support to practices that support abortion outside the following legislative framework: when the pregnancy threatens the health of the mother, in case of rape, and in case of incest. This policy – which had a very restrictive financial support regarding the promotion of safe abortion and family planning – was lifted in 1993 under the Democratic Clinton administration, restored in 2001 under the Republican administration of George W. Bush (Corbett and Turner, 2003), and was rescinded again by the Democrat Barack Obama.

Chapter 3: Research design

In this Chapter I will explain how this research has come about, and I will give more details regarding the methods used to describe factors that influence women's access to PAC in Burkina Faso. Research approaches have multiplied and give many choices to the researcher. For those designing a proposal or plan, it is recommended that a general framework be adopted to provide guidance about all facets of the study, from assessing the general philosophical ideas to the detailed data collection and analysis procedures (Creswell, 1994).

Theoretical perspective

Malterud (2001) considers the theoretical frame of reference to be "the analyst's reading glasses". For her, the theoretical frame of reference can be described as theories, models, and notions applied to the interpretation of the material and for understanding a specific situation. Ethnography, phenomenology, and institutional theories of organizations have been the most influential theoretical perspectives in this research.

Ethnography is defined by Brewer (2000: 6) as: "the study of people in naturally occurring settings or 'fields' by means of methods which capture their social meanings and ordinary activities, involving the researcher participating directly in the setting, if not also the activities, in order to collect data in a systematic manner but without meaning being imposed on them externally". It is considered as a style of research rather than a single method, and uses a variety of techniques to collect data (ibid). Ethnography has also been commonly connected to the idea of holism; cultures are interconnected, not fragmented; they are whole systems, and therefore any description of them, to be complete, must tackle the whole (Nader, 2011). The description appears as a central element in ethnography, which is why Laura Nader (ibid: 211) considers it as "*a theory of description"*. For her, an ethnography which gives a description, an explanation of facts, can be considered as a theory. Data from this research have been collected doing hospital-based ethnography using different methods and different sources of information, approaching PAC as a complex and embedded phenomenon which involves multiple actors and health care services.

Phenomenological approaches are based in a paradigm of personal knowledge and subjectivity, and emphasize the importance of personal perspective and interpretation. Phenomenological methods are particularly effective at bringing to light the experiences and

perceptions of individuals from their own perspectives (Lester, 1999). This research addresses the problem of PAC in Burkina Faso from the perspectives of many actors: Women, their relatives, and health care providers.

Studying PAC access in a hospital setting, which is presented as a complex organization (Machado and Burns, 1998), justifies my reference to the institutional theories of organizations. Indeed the institutional theories of organizations provide a rich, complex view of organizations. In these theories, organizations are influenced by normative pressures, sometimes arising from outside the organization, or sometimes from inside the organization itself (Zucker, 1987). The operation of the hospital, the rules establishing the organization of health care, the social and professional identity of health care providers, and user behavior are all factors that can influence the management of unsafe abortion.

Methodology

Many abortion cases occur in an illegal context in Burkina Faso. Collecting data on an illegal practice is notoriously difficult (Rossier, 2007). My research focus on PAC offers a less controversial entry point than a study of abortion in general. However, to study PAC ethnographically necessarily involves speaking also about the *experience* of abortion, and studying how women interact with their social environment (hospital, household, neighborhood, workplace, etc.) *after* an abortion. Ethnography is a very useful method to address health issues. In particular, it can generate rich and varied data on interactions between health professionals, patients, and their relatives, as well as in-depth understanding of patients' care seeking experiences (Reeves et al, 2008). Following Öhman (2005) this research used an emergent design, which gives the researcher the ability to change and adapt the research process in accordance with emerging results. The following section shows how this research has been constructed through the data collection process. However, before presenting this point, it will be relevant to present some background information about Burkina Faso and the study site.

Country Profile

Burkina Faso is located in West Africa, and extends over an area of 274 200 km2. It is bordered by Mali, Niger, Benin, Togo, Ghana, and Côte d'Ivoire. The country is divided into 13 regions, 45 provinces, and 351 municipalities. The capital city is Ouagadougou. In 2011

the population was around 16,000,000 inhabitants (MHOB, 2012). The majority of the population (77%) lives in rural areas. (INSD, 2008). The birth rate is 46 per thousand. The population is predominantly young, with 46.4% in the 0-15 year age bracket. The Total Fertility Rate (TFR) is 6.2 for the whole country and it is among the highest in Africa. The contraceptive use from 1990 to 2008 was 17, 4 %, and was relatively low compared to other countries in Africa (PNUD, 2010).

Burkina Faso has one of the highest maternal mortality ratios in Africa. Data from the National Institute of Statistics and Demography (INSD, 1999) estimated the ratio of maternal mortality to 484 deaths per 100,000 live births. This ratio was estimated at 307 deaths per 100,000 live births by Banza et al (2006), presenting data from INSD (2006). More recently, UNICEF (2010) estimated (adjusted) the ratio at 300 maternal deaths per 100,000 live births. According to the Minister of Health of Burkina Faso (2011), abortion complications were the fourth most common direct cause of maternal death, after hemorrhage, infection, retained placenta, and uterine rupture.

The low level of education, the economic status of women, and the lack of strong signs of complications of pregnancy, are contributing factors to the high level of maternal deaths. Moreover, the user fees implemented in the country since 1993 have had a negative impact on health service utilization because of financial issues (De Allegri et al, 2010). In order to reduce these problems the Government adopted a policy for the period 2006–2015 to subsidize deliveries and emergency obstetric care at 80 % (Ridde et al, 2011). Under this subsidy, women are required to pay 900 CFA Franc for an uncomplicated delivery, 1800 CFA Franc (3.5 US dollars) for a complicated delivery, and 11,000 CFA Franc (22 US dollars) for a C-section. These values correspond to 20% of 9000 CFA (18 US dollars) for a complicated delivery and 55,000 CFA Franc (108 US dollars) for a C-section (De Allegri et al, 2010).

Even if the use of services has increased after the implementation of this policy, its implementation within the health system faces difficulties (Ridde et al, 2011). A recent study conducted by Storeng et al (2012) on the indirect causes of maternal death in Burkina Faso has shown the weaknesses in the health-care system and the social and structural barriers to health care for women after near-miss obstetrics complications.

Figure 3: Map of Burkina Faso (Ministry of Foreign affairs, 2004)

The Organization of the health system in Burkina Faso

The Ministry of Health consists of three levels in its administrative structure:

- The central level, consisting of the organized central structures (activities);
- The intermediary level, which includes 13 regional directorates of health
- The peripheral level, consisting of sanitary districts, which are more decentralized entities in the national health system.

Public healthcare structures are organized in three levels which provide primary, secondary and tertiary care. The first level corresponds to the sanitary district which includes two levels: The first level of care provides primary care. In 2011, there were 1,443 primary health centers. In addition, there are 36 Medical Centers (MC).The second level of care is the Medical Center with surgical Antenna (CMA). It is the centre of reference for the health of the district. The second level is represented by regional hospitals. They serve as a referral to the

CMA. The third level consists of the University Hospitals. They are the highest level of referral. In 2009 the number of regional hospitals was 9, while the university hospital centers were 3 in number (Ministry of Health of Burkina Faso, 2010). My study has been conducted in one of them.

In addition to the public structures, Burkina Faso has private health care structures concentrated in the cities of Ouagadougou and Bobo-Dioulasso. In 2011, there were 381 private care structures in these two cities. The importance of traditional medicine is recognized by the law since 1994. The country has more than recognized 30,000 traditional healers. (MHOB, 2012)

Study Sites

Data collection took place between August 15, 2012 and January 5, 2013 in three departments within the "Yalgado" Hospital in Ouagadougou, which is a university hospital in Burkina Faso. The departments were: The Department of Gynecology and Obstetrics Care, the Department of Internal Medicine, and the Department of Nephrology. The decision to include both the Department of Internal Medicine and the Department of Nephrology in the study emerged during data collection, because I found that they were heavily involved in the provision of PAC during the field work, even though PAC is formally located in the Department of Gynecology and Obstetrics Care.

The Yalgado Hospital was established in 1961 to supply curative, preventive, and rehabilitation care, to train medical staff and teach medical sciences, to manage referred patients, etc. To accomplish its mission, it has several services, including health care services and paramedical services (laboratory, blood bank, pharmacy, etc.). The gynecology and obstetrics service is referred to as the "maternity" by both users and by care providers, and presents itself as the highest level of reference for maternity in surrounding cities. The Department of Gynecology and Obstetrics Care was the principal site of data collection.

The Department of Gynecology and Obstetrics Care includes four buildings and two dedicated waiting areas (one of which is outside). The first building, which his referred to as the 'old building' by health providers, includes the units for resuscitation and awakening, post-surgery, pathological pregnancy, and post-delivery and gynecological consultation offices.

The second building is a small house where the Officer responsible for the services can be found. It also includes an ultrasound room. The third building is adjacent to the gynecological consultations. It consists of units such as a delivery room, abortion care unit, intensive care unit, surgical, resting rooms, and a pharmacy for emergency obstetric and neonatal care drugs (for those drugs covered by the new government subsidy for maternal health care). The fourth building is detached from the other buildings, and is located in front of the 'old building'. It includes the meeting room and the unit of Family Planning (FP). The activities of the service in the Department of Gynecology and Obstetrics Care are deliveries, PAC, surgeries, curative care of hospitalized patients, contraception and family planning support, cervical cancer screening, newborn care, and consultation in gynecology for outpatients.

The staff consists of gynecologists, obstetricians, anesthetists, physicians in specialty training of gynecology and obstetrics, midwives (both male and female), nurses, aid anesthetists, aid operators, medical students, porters, waitresses, advisors in mother to child transmission of Human Immunodeficiency Virus (HIV), a cashier for payment**, a** drugs keeper, and a secretary. The staff also consists of a non-permanent staff composed of nurses and midwives (males and females) from the National School of Public Health and from a private public health school. The gynecologist-obstetricians and midwives are the most involved in providing PAC.

The service is headed by a head of service (a Professor in gynecology and obstetrics). Continuity of care is provided 24/7 hours. Permanence is assured from 8 A.M to 5 P.M. and custody from 5 P.M to 8 A.M. Each team consists of 1 gynecologist obstetrician on call, 4 physicians specializing in gynecology and obstetrics, 3 midwives (males and female), 2 nurses, 2 aid anesthetists and 2 aid operators, Medical students, 1 porter and 1 waitress.

Methods

In keeping with the research objectives a combination of ethnographic methods was used, including consultations of documents, observation, and formal, in-depth interviews as well as informal interviews.

Consultation of documents

I initiated my research by a literature search, performed before and after data collection (this review is reported in Chapter 2). It allowed me to have more information on my subject, through the eyes of researchers who have addressed the same theme. My research also leads me to relevant political documents.

Documents are useful resources in ethnography. Official statistics and records, letters photographs and media products can be used to sensitize the ethnographer and open up potential worlds for scrutiny (Seale, 1999). To inform my analysis, I consulted medical records, health records, and hospital records of PAC patients and prescriptions. I also observed posters and information on the wall of the Service of Gynecology and Obstetrics Care. Information from these documents is used in both the findings and the discussion chapters.

Observation

Because of the social status of abortion in Burkina Faso, to mention a study on abortion in a hospital sitting where women and health workers meet in the framework of PAC supply creates trepidation or reluctance among potential research subjects. By observing interactions between the actors involved in the supply of PAC, I aimed to understand the potential gap between the discourses of research participants and their practices. The main advantage of observation as a method of data collection is to avoid the biases inherent in participants' reports (Fitzpatrick and Boulton, 1994) and observe the discrepancy between discourse and practice. By doing observation, I also wanted to reflect on my pre-conceptions and my position as a researcher, and thereby give more relevance to my data. I had both the position of a non-participant observer and that of a participant observer. Non-participant observation is particularly useful when the researcher aims to describe and conceptualize the "taken for granted" practices of everyday medical life (ibid), while the importance of participant observation is that it enables the researcher to become familiar with the assumptions and rules which animate the social environment under scrutiny (Porter, 1991).

Participant observation in a hospital raises ethical issues. In order to avoid harming my participants, I took the responsibility to make conscious decision on what to report and what to decline to report, based on careful consideration of the ethical issues that may affect my

informants, and the goal of my research (Dewalt et al, 2002). The ethical issues raised during the field work will be discussed in the section on reflexivity below.

I observed interactions between women and health care providers, between women and their relatives, and between women, relatives, and health care providers. My attention was focused on their talk and their actions during their interaction.
Observations were conducted both in the hospital and at the home of one PAC patient. Inside the hospital, I came and went between three services (Internal Medicine, Nephrology, Gynecology and Obstetrics Care), enabling me to follow patients as they were transferred from one department to another. In addition, casual visits were made to the Department of Nephrology and Internal Medicine to maintain contact with health care providers. Inside the Service of Gynecology and Obstetrics Care, I regularly visited women who were hospitalized in the unit of intensive care and in the MVA unit. I often sat in the waiting rooms with women and their relatives.

I observed seven women who came for PAC. Among them, one had been referred from the department of Gynecology and Obstetrics Care to the Department of Internal Medicine, and one had been referred from the Department of Medical Emergency to the Department of Gynecology and Obstetrics Care. The same woman was supposed to be referred to the Department of Nephrology, but she had not been finally referred.

I took notes discreetly during observations. I stored what I saw as relevant in mind, and wrote it down later. I regularly talked to health workers about the issue of abortion, creating familiarity with them, and allowing me to collect useful data for my research. I also regularly guided the relatives of women around the hospital (laboratory, pharmacy, blood bank) as they collected drugs and other equipment for their hospitalized relatives. These roles allowed me to be close to women and their relatives, and to establish a good relationship with them. I was often asked to translate a conversation between health workers and women. These multiple roles facilitated my immersion in the field. Observations were complemented by interviews.

Figure 4: photo of MVA room in the study site

Interviews

PAC patients, relatives of PAC patients, and health care providers are my research participants. The three groups of research participants were approached and recruited in different ways. Methodologically, it is difficult to reach women who have undergone an abortion at the community level because abortion is not always an open topic in the community. Recruiting the women from a health center where they seek care after an abortion was therefore best solution for me. Because I am not a health care provider I was not allowed to use confidential medical records to identify participants, and therefore depended on assistance from health providers in identifying and recruiting PAC patients. The first step in obtaining participants' informant consent was the health care providers. After giving them information about my study, they introduced me to those patients who might want to participate in the research. After this step, I provided all the information about the research (purpose, risks, benefits, significance, confidentiality, freedom to participate or not, etc.), and requested the participants' informed consent. In two instances, I identified a PAC patient

through informal encounters, and requested permission from health care providers to approach them about the study. Once they agreed to participate, I arranged a time and place for an interview.

Between October 2012 and January 2013 I carried out open-ended in-depth interviews with six women and five of their relatives, lasting between thirty minutes and one hour. They took place in locations chosen by the patient, such as in their home, or at the hospital. The interview guide for the women covered themes such as their reproductive history, the conditions under which they lost the pregnancy, their perception of abortion and their definition of PAC, the challenges they face when seeking care, and the support from their relatives. The same guide has been used to discuss with patients' relatives. The interviews were conducted in French or in Mooré, depending on the patient's language skills and preferences, and were tape-recorded and transcribed verbatim. Purposive sampling has been used to choose and to recruit women. In purposive sampling, the researcher actively selects the most productive sample to answer the research question (Marshall, 1996). The choice of women was guided by criteria such as the type of abortion diagnosed (whether induced or spontaneous), whether patients were referred from others health centers or arrived directly from home, the length of hospitalization, and whether patients were transferred from other health care inside the hospital.

The six women who were interviewed ranged from 17 to 42 in age. Four admitted to having had an induced abortion, while two reported spontaneous abortion. Four of them were single, while two of them were married. Three of them were doing small trading as an occupation; two of them were studying, while one reported she did not have any occupation (see Table 1).

I also interviewed relatives of PAC patients, who often accompany women in the hospital and who are often well informed about the facts surrounding the patients' care and involved in their financial, moral and social support. As they interacted a lot with women and the health care providers in the hospital, they appeared to be key actors for understanding the difficulties women may face when seeking hospital care after abortion. The decision to include them in the research was taken during the data collection, when I became aware of their involvement in the medical follow-up of the women. When I felt that it could be useful for me to interview a woman's relative, I first discussed this with the woman to see if the person supporting her at the hospital was aware of her situation, and asked her permission to approach them. Five

relatives of women were interviewed: two mothers, one father, and two sisters. Among them were two sellers, one hairdresser; one technician and, one housewife (see Table 2).

During interviews with the women and their relatives, instead of using the term "abortion" - which does not exist in my participant's local languages - I said "the pregnancy which stopped before the end". This led interviewees to express their ideas freely and to say things as they perceived them. I avoided asking sensitive questions at the beginning of the discussion in order to maintain a good atmosphere during interviews.

I also interviewed nine health care workers. The recruitment of health care providers was based on their availability, their willingness to participate in the research, and their professional background and function. For example, midwives and gynecologists do not have the same level involvement in PAC. Among the health care providers I interviewed, some of them gave care to the women I interviewed, while others were assuming administrative roles. It is good to have both their perspectives on PAC. The interviews were in tape-recorded, lasted between thirty minutes and one hour, and were conducted at the hospital, in French. Among the nine health care providers we interviewed three were men and six were women. As for their professional background, three were gynecologists, four midwives and two nurses (see Table 3). The interview guide for health personnel covered themes about their perception of abortion and their definition of PAC, the supply of PAC (including questions about the cost issues), and all kind of facts they consider as challenges for women in getting access to quality care. The interview guide was not, however, followed strictly. Rather, I used it to launch key themes, but then probed and explored my interviewees' emerging responses. This allowed me to be responsive to relevant issues raised by the interviewee.

Table 1: List of interviews with PAC patients

Participants	Place of interview	Marital status	Age	Occupation	Type of abortion
1	Hospital	Single	19	Nothing	Induced
2	Hospital	Single	19	Student	Induced
3	Home	Single	17	Student	Induced
4	Home	Single	21	Seller	Induced
5	Hospital	Married	26	Seller	Spontaneous

6	Hospital	Married	42	Seller	Spontaneous

Table 2: List of interviews with PAC patients' relatives

Participants	Place	Link with the patient	Occupation
1	Hospital	Father	Technician
2	Hospital	Mother	Seller
3	Hospital	Mother (widow)	Seller
4	Hospital	Sister	Housewife
5	Hospital, home	Sister	Hairdresser

Table 3: List of interviews with health care providers

Participants	Place of the interview	Gender	Occupation	Department
1	Hospital	Male	Gynecologist	Gynecology and obstetric
2	Hospital	Male	Gynecologist	Gynecology and obstetric
3	Hospital	Female	Midwife	Gynecology and obstetric
4	Hospital	Male	Gynecologist	Gynecology and obstetric
5	Hospital	Female	Midwife	Gynecology and obstetric
6	Hospital	Female	Medical student	Gynecology and obstetric
7	Hospital	Female	Medical student	Gynecology and obstetric
8	Hospital	Female	Nurse	Emergency Visceral

9	Hospital	Female	Nurse	Nephrology

Informal discussion

Informal discussions were conducted during interactions with PAC patients, their relatives, and health care providers. Much of the data was collected by this method, especially with the health care providers. Indeed, observations showed that health care providers shared much more sensitive information during informal discussion than during the formal interviews. This is certainly due to the sensitivity of the subject. Because of the sensitivity surrounding the topic, health care providers addressed the theme with some carefulness, while women addressed it with some fear. They became more relaxed when the discussion was not recorded and I was not taking notes.

Data Analysis

A qualitative study usually relies on inductive reasoning processes to interpret and structure the meanings that can be derived from the data (Thorne, 2013). In my research, the data analysis was an on-going process, during and after the data collection. Four interviews with health care providers and two interviews with women were transcribed during the fieldwork. Each day after leaving the field, I read or listened to all the materials (field notes, what I had written down from informal discussions, observations, interviews) in order to get an overall impression of the preliminary findings. After this step, I identified different categories and sub-categories of meaning that represented the perception and the experiences of my participants. If some themes were already pre-determined before the field work, some other themes emerged during the data collection process. For example, perceptions on abortion and PAC as categories were pre-determined before the field work, but the themes of the limitation of the comprehensive approach of the concept of PAC emerged from the field, when I noticed that some patients were referred to other departments of care from observations. Unclear questions were written down to be verified or clarified. Most of the clarifications with participants have been done through informal discussion. Having these preliminary thoughts about my findings from the field work allows me to assess the quality of the obtained data. All this has contributed to the validity of my study. Validity, in qualitative research, refers to whether the findings of a study are true and certain; “true” in the sense that research findings accurately reflect the situation, and “certain” in the sense that research findings are supported by the evidence (Guion and al., 2012).

Data triangulation involves using different sources of information in order to increase the validity of a study. In this study, the different sources that have been triangulated include open-ended interviews with women, women's relatives, and health providers, direct observation, health records and other documents, women's medical prescriptions, and photos. The data from each method complemented each other, and helped me achieve an in-depth understanding of the research topic.

After the field work, the rest of the interviews (7) were transcribed and read to get an overall view of the transcripts. Then I identified themes and coded the transcripts. Before analyzing the materials, discourses and facts observed from interviews and informal discussions with the women, their relatives, and health care providers, and from other observation, have been arranged together according to the similarities they have with each other.

Reflexivity

Reflexivity refers to active acknowledgement by the researcher that her/his own actions and decisions will inevitably impact upon the meaning and context of the experience under investigation (Horsburgh, 2003). It is therefore important to account for how my personal position impacted on the research.

The choice of topic reflects my previous research experience in maternal mortality in the framework of a Master degree (M1) in Sociology at the University of Ouagadougou (UO) in 2007, where I found that the number of abortion-related deaths was significant. I told myself that if I had the opportunity one day to continue my studies, I was going to look at questions related to unsafe abortion. In 2010 I got a chance to be involved in a research project on the costs of reproductive health care in West Africa (Burkina Faso and Gambia) funded by the Research Council of Norway. In Burkina Faso we decided to focus on the social and economic costs of abortion. I decided to work on PAC, where I developed my interest for finding out what the challenges are that women may face when seeking hospital care, using a qualitative, ethnographic approach with field work at the hospital.

In addition to the ethical clearance I obtained from the ethical committee of Burkina Faso, I decided to ask for a permission to conduct my field work inside the hospital. Indeed, I

assumed that being officially introduced at the hospital could facilitate my field work. A first contact was made June 2011, when I did some preliminary research.

After obtaining all permissions, I began my investigation by first informing caregivers about my study. I explained to them the object of the study and my presence at the hospital. Most of them already knew me because of my previous research experience. Some even said: “welcome. You know this house better than us. Go ahead”.

The caregivers’ welcoming attitude gave me freedom to proceed as I wanted. But for me, that was not a good starting point, because I needed to see the hospital as the place of my “work” instead of seeing it as my home. Affinities with caregivers, and the freedom given to me, could be an obstacle to the objectivity of my work. I decided to put restrictions on myself in order to respect not only the methodological requirements, but also the ethical requirements during the field work. I positioned myself as a “researcher”.

Positioning myself as a researcher gave me an opportunity to stand back from anything that could undermine the quality of my work, such as confidentiality-, ethical, and privacy issues.

Furthermore, my data collection through observation led me to interact with caregivers, women, and their relatives at the hospital. My social identity and my professional status as a student coming from the University of Oslo (UiO) affected my relationship with these actors:

I am from an ethnic group called "samo", located in the North West of Burkina Faso. In the Burkina Faso tradition there is an alliance between my ethnic group and the "moosé" ethnic group. These alliances result in relationships through jokes, and can help people to establish good relations with each other. The majority of the people I met during my data collection came from the “moosé” ethnic group. They did not hesitate to tease me and to use a friendly tone with me, which helped negotiate and reinforce my collaboration with them.

Speaking several languages (French, English, dioula, san, moore) also helped me to improve my relationship with my participants, as I often played the role of interpreter between caregivers and patients. For example I have been asked play the role of interpreter for one PAC patient who spoke only English, which helped establish a good relationship between us.

I presented myself as a master's student collecting his data. Despite the fact that I was trying to show this student status, some caregivers continued to see me as a researcher coming now with a funded research project. They often called me “the sociologist”. For them, I had started "to eat", and I had to share with them. They often said: “we struggled together here, now you got a project and you forgot us." They expressed themselves with a joking tone that sometimes made me uncomfortable. However, the others were curious to know how I got admitted to UiO, and asked for information about opportunities to study in Norway. I

therefore had an "extra job" in the field work: talking about Norway and its opportunities. These talks certainly did not have a link with the subject of my research, but once more helped improve my relationship with the caregivers.

My gender also impacted on my research. Much of the research on abortion is led by women, possibly due to men's difficulties interviewing women about what is a fundamentally female experience (Dollar, 1997). Before starting my data collection, I had the premonition that my gender was going to have a negative influence on the willingness of women to participate in my research. However, being a man has been an advantage for me. In fact, the presence of both male and female midwives at the hospital has contributed to that, because women were willing to participate when they initially thought that I was a male midwife. This probably reflects the stereotype that male midwives (*maieuticien*) in Burkina Faso are kinder than female midwives. In fact, women are said to prefer to deal with men rather than women at the hospital. This perception worked in my favor. By the time I was able to explain to them that I was not a health care provider, they had already agreed to discuss with me. When they eventually found out I was not a health care provider, they were more confident to share with me their experiences with health care providers.

Ethical Considerations

According to the declaration of Helsinki, medical research and health related research must contribute to the well-being of the society (World Medical Association, 2008). Furthermore, populations that are made the subject of medical research should benefit from the results of the research (ibid). This study is beneficial for society and for women in general rather than directly beneficial for its participants. However, it has been argued during a conference on research in developing countries that "fair benefits" has to rely on three widely ethical conditions (Bedru and Ruyter, 2009): First, the research must address a health problem of the developing country's population. Secondly, the research objectives must provide a strong justification for conducting the research in this population; and, thirdly, the research must pose few risks to the participants, or the benefits to them clearly must outweigh the risks. This research does indeed address a problem, namely that of getting access to PAC in Burkina Faso, one of the poorest countries in the world. In addition, abortion-related deaths in hospital settings are high. This research can contribute to the improvement of practices and policies by making some positives changes in the provision of PAC by targeting some of the barriers identified in this research. The study may also contribute to the scholarly research and

literature in the field. The study provides data on issues of social support and structural factors related to women's health after an abortion.

The Norwegian Regional Committee for Medical and Health Research Ethics and the Ethical Committee of the Ministry of Health of Burkina Faso approved the study.

The regional Direction of Health and the General Director of the University Hospital also approved the study. The Department of Gynecology and Obstetrics Care, the Department of Internal Medicine, and the Department of Nephrology approved the data collection within their Departments.

Informed consent forms were read out loud to the research participants, who provided oral consent by their own whish. Oral consent was also the most suitable because of the sensitivity of the topic for both the health care providers and the women. All participants were told that they could withdraw from the study at any time, or choose not to participate in the study, with no negative influence on their treatment at the hospital.

To protect my informants' privacy, I anonymized the names of research participants. The women are quoted using fictional names, while their relatives are quoted based on the relationship they have with the patients, for example "the mother of…". health care providers are listed according to their professional identity only, for example "midwife", "nurse", "medical student".

Chapter 4: The findings of the study

This section presents the findings from data collection at the hospital. These data have been provided from interviews and informal discussions with health care providers, women and their relatives and from our observations and documentary sources. They highlight the problem of PAC in hospital setting and the difficulties that women face in accessing care. The findings show that women, their relatives and health care providers have negative perception on abortion and share virtually the same perception while their perception on PAC present several issues related to their experiences and their understanding of this concept. Women face various types of barriers when seeking for hospital care: Social and financial barriers as well as barriers related to the management of PAC. From the experience and report of women, their relatives and health care providers, the findings show that PAC is not only a medical problem, but depends on health, economic and social factors.

4-1-Case presentation: The "fight" for basic PAC and "the road to death"

While I was conducting participant observation in the Department of Gynecology and Obstetrics at the main university hospital in Ouagadougou, I met a social worker who informed me of an abortion case under her responsibility. The woman in question had been hospitalized, but did not have a relative or friend accompanying her to help her manage in the hospital, and also lacked financial resources. According to the social worker, the girl had been transferred from the Department of Gynecology and Obstetrics to the Department of Internal Medicine.

I therefore decided to go to the Internal Medicine Department to learn more about the case. Along the way I met a health worker with a pack full of drugs. Talking to her colleagues, she explained: "all this is for one of our patients that I went to ask for." That patient was named Tina.

Tina was a 39-year-old widow with three children, who had left her country to join her younger sister in Burkina Faso. Upon her arrival in Burkina Faso, she met new friends, and started to go out with them. Her sister explained that she got a job waitressing in a pub. Three months after her arrival, she confided to her sister that she was pregnant and would like to get rid of the pregnancy, which was four months into the gestation period. Her sister tried to dissuade her from doing so. First, Tina tried to terminate the pregnancy by drinking a mixture of whisky and "Nescafe" (a common method for self-inducing abortion), without any success. After that, she decided to seek help from an abortionist. According to her sister, the abortionist

was a lady who pretends to be a health worker. Again according to Tina's sister, this lady is well known in Tina's workplace, as girls often resort to her for an abortion. After she had been informed about the complications Tina experienced, she switched off her mobile phone and disappeared. The abortionist took 30,000 FCFA from Tina to induce the abortion. The procedure involved maneuvering in her uterus, using a chisel. Afterwards, the abortionist advised her to drink warm water, and to take an amoxicillin and ibuprofen.
During the same night, Tina began to bleed profusely. After some hesitation, her sister took her to a medical center. Tina's sister was hesitant because she was angry at Tina for not listening to her and trying to get rid of her pregnancy. According to the sister, she wanted to let Tina struggle alone with her situation, but she also thought that Tina might die, which would be more problematic for her. And so, at the end of September 2012, she decided to take Tina to the hospital. Tina spent three days at the local medical center, but her problem was not properly diagnosed because she refused to talk to the health care providers. Suspecting that she had had an induced abortion, the medical center decided to transfer her to Yalgado Hospital – the main referral hospital. Her sister reported to have spent 95,000 FCFA during the three days Tina was at the medical center.

In early October 2012, Tina was directly admitted from the medical center to the Department of Gynecology and Obstetrics Care at Yalgado Hospital (after spending 3 days in the medical center). According to her sister, a health worker who was taking care of her there was shocked when Tina openly told him that she had wanted to get rid of her pregnancy. He left her, and never returned to her bedside. Her sister was also angry at Tina for her candor; she had advised Tina to concoct a story that she lost the pregnancy after a fall. After a few days of hospitalization, the caregivers decided to transfer her to the Department of Internal Medicine, to be treated for acute peritonitis.

At the Department of Internal Medicine, the health care providers told me that Tina was alone, and that they were trying to get in touch with her family. As she spoke only English, they asked me to talk to her to get information about her relatives. It was clear from our discussion that Tina had a sister, who often came to visit her in the hospital. The health care providers confirmed to me that someone brought her food regularly, but they had never managed to get in touch with that person. Meanwhile, Tina had already undergone a surgical intervention, and should normally be transferred to another unit to receive adequate care. However, the health care provider who was in charge of her referral was afraid that nobody would take care of her

in that care unit (Surgery B), and had decided to keep her in the Department of Internal Medicine. Her colleagues called this health care provider “Tina’s Mom” because of the way she took care of her, not only providing medical care, but also regularly bringing her food. "Tina’s Mom" played the role of caregiver, relative, and social worker.

A few days after her first surgery, Tina underwent a second surgery. Tina had no money to buy the given prescriptions, but she was able to get a surgery kit from the Department of Gynecology and Obstetrics for the first surgery through the assistance of her “Mom”. For the second surgery, the financial difficulties appeared again. This time, there was nobody to buy drugs for her. Her “Mom” tried to find the necessary drugs for her surgery, by talking to a social action worker and a religious community group located inside the hospital. The religious group provided 10 bottles of nutrients (a bottle cost 25, 000 F CFA in the pharmacy). She also got a kit for surgery, which costs 63, 000 CFA francs, on credit (without paying for it).

Two days later, the health care providers were finally able to get in touch with Tina’s sister. They threatened her, and told her that she should remain at the bedside of her sick sister permanently. At the end of October 2012, when Tina had been hospitalized for nearly a month, I finally met Tina’s sister in another unit, “the surgery B”, to which Tina had been transferred. When I wanted to know why she was not often around when people were looking for her, she answered me in these words, while smiling:

> "I went for the first time to social action to ask for drug one time. The second time I refused to go there. Because they asked me too many question the first time. I had no money so I fled from the hospital. I was just coming only to drop the food and then I flee. One day the health providers caught me and they even wanted to beat me. But when I showed them all the prescriptions I have bought for my sister they tried to understand me and since these days they also tried to support us”

A few days later, she brought some prescriptions that she had already paid for Tina. Together we counted the total amount of expenditure to 62,360 FCA francs.

Tina was admitted to a new ward, and I regularly visited her there. She was accustomed to my presence, and often asked me for small favors. Other patients who were hospitalized in the same room with her left the room because of bad smells emanating from Tina. Tina urinated and defecated on herself because she was unable to go to the toilet, and the room was full of insects. A relative of one of the patients who shared her room told me that caregivers also avoided the room, except one other nurse (not her “mom”), who often came to clean and to

help her take her medicines. Tina's sister, meanwhile, expressed the desire to take her back home. According to her, nobody was taking care of Tina, and her health condition was getting worse and worse. One day, I accidentally met the nurse who often visited her. When talking about the case of Tina, she said:

> "I made her dressing on Sunday. This is supposed to be done every day. Nobody visits her room, even the medical students run away from her. Last time I asked a student from the public health school to help me do her dressing. If I am not here she will not have any treatment. But I cannot be there all the time. I am going home right now. If tomorrow I do not come she will not receive any care."

Three days after I met the nurse, I found Tina's bed empty. Caregivers told me later that she had decided to go home. After getting in touch with her sister, I decided to visit their place. Her sister told me that she was the one who took the decision to bring Tina back home, so that she could be treated with respect. She said she was scared that Tina would die at her place, because their relatives in their native village in their country would blame her (the sister). To avoid these troubles, her sister decided to hire a nurse to do Tina's dressings at home. The nurse was given 3,000 F CFA per day. After providing care for five days, the nurse also gave up, and advised them to go back to the hospital. Tina's sister was exhausted. She no longer had any money left, and she had not paid rent for two months, owing 50,000 FCFA to her landlord. They could not get any support from their neighbors, because even before her illness, Tina did not have good relationships with them. Her sister decided to seek help from a social organization for their country's citizens in Burkina Faso. Because Tina and her sister were not members of the organization, and were not involved in its social activities either, the organization refused her. After this failed attempt she decided to seek assistance from their country's Embassy, showing them pictures of Tina in her very bad state of health to justify her demand. Some days later, a caregiver from Yalgado hospital gave me 3,000 F CFA that some patients had collected for Tina. Tina was refusing to take food and medicines from the hands of her sister, as she reprimanded her almost all the time. Her sister welcomed my presence, because Tina accepted food only from me, and she followed my advice to take the medicines.

In the middle of November 2012, Tina's sister decided to take her back to the hospital, to the Department of Internal Medicine. According to health care providers, Tina was too weak to support the surgery, so they transferred her to the Department of Resuscitation to identify her central venous line, in order to transfuse her nutrients. Tina was scared of her new hospital room, and said she thought the health care providers wanted to "kill her". She was crying and

saying: “"holy ghost fire, holy ghost fire”. A health care provider heard about her fear of “death” and said: "she killed and then she is afraid of death...".

Tina should have undergone another surgery, but according to a health care provider she was too weak, and they were trying to give her nutrients to make her physically strong enough for the second surgery. Her sister told me that she had never expected Tina to reach this period of time in her life, because of all the challenges they faced. According to health care providers, Tina was lucky, because she got a lot of support from them – she got a lot of care without paying for it. Several other patients did not receive this opportunity (according to health care providers). Even with Tina’s bad health condition, they were “confident” that she would not die – contrary to what they thought when they saw her for the first time. According to Tina’s sister, she usually had a lot of hope that she would survive. One day, said her sister, Tina stroked her chest and said: “me I will not die I will survive”.

Two weeks later, however, I received a call from Tina’s main health care provider asking me to inform Tina’s sister, whom they could not get in touch with, that Tina had died. Tina did not survive her post-abortion complication. She died in December 2012, at Yalgado hospital in the Department of Internal Medicine, while waiting for her third surgery.

Figure 5: Photo showing some the prescriptions paid by Tina's sister.

Tina was admitted into the health system in a poor health condition because of the consequences of her unsafe illegal abortion. At the hospital she faced financial difficulties, and was later admitted to a Hospital Department where her care was no longer subsidized, as it was no longer formally part of the package included in PAC. The case of Tina shows how social constraints, the weaknesses of PAC policies, and the attitudes of some caregivers, can contribute to limited PAC.

4-2-Perceptions of abortion and PAC

How are abortion and PAC perceived? In order to understand how PAC is experienced in hospital context, it is crucial to get an overview of the perceptions of the different actors who are directly or indirectly involved in the management of PAC.

4-2-1- Perceptions of abortion

Most of the local languages in Burkina Faso refer to abortion as a spoiled pregnancy. In the Moore language, for example, abortion is referred to as*"pug n same*". *"I samapuga",* which means "she spoiled the pregnancy", refers to an induced abortion, and *"pugasaman me",* which means *"*the pregnancy spoiled itself", refers to spontaneous abortion. To mention the term *"avortement"* (French word) suggests an induced abortion. Even women received for spontaneous abortion express this perception. Zara, is an example. She had been admitted for spontaneous abortion, according to the health care providers, and she underwent MVA. When she talked about her experience, she said:

"When I started to bleed I decided to go to the medical center. They told me that it looks like the baby does not live anymore. They asked us to do an ultrasound. When we showed them the results of the ultrasound, they advised us to do an abortion and they referred us here (hospital Yalgado)… Here also we have been told the same thing. Then we accepted to have the abortion."

When I asked her perception of abortion, instead of answering the question directly, she tried to justify why she had undergone MVA. In these remarks, Zara seems to highlight the fact that she was surrendered to the decision of the caregivers. Indeed, she considers the MVA as an act of abortion. Zara's response is understandable from the fact that the question has been asked using the term "avortement," which implies the idea of an induced abortion. This tendency to equate the term abortion with *induced* abortion was expressed by all the women involved in the study. However, they systematically differentiated between spontaneous abortion and

induced abortion later on in the interview, when I used the expression of “spoiled pregnancy” in the language they were speaking (Mooré, Dioula, French).

Health care providers also use the term abortion primarily to refer to induced abortion, but they also use it to highlight which kind of abortion is considered problematic. As expressed by the words of this gynecologist:

“When it comes to abortions, we do not consider spontaneous abortions because it happens in a natural context and there is less problems. The problem remains with the induced illegal abortion”.

Women and health care providers thus to some extent misused the term abortion, assigning it only to induced abortion. The use of the expression is blurred. So for Zara, the intervention she had to undergo to remove a fetus that died from a spontaneous abortion, comes to constitute an ‘abortion’ (about which she is ashamed).

Women, their relatives and the health care providers shared the position that abortion is not a good thing, often referring to moral and cultural values to justify their view. For instance, the mother of Therese, a 21 year-old girl who was admitted to hospital after an induced abortion, said:

"Young girls today they take their pregnancy and abortions while there are people seeking for a child. It is not good to take the life of someone. In the past, even our husbands were struggling to have sex with us. But nowadays girls already have sex before getting married and they cannot avoid pregnancy! If they could have kept themselves away from men I would have not been here today.”

For Therese’s mother, sexual abstinence before marriage could prevent induced abortion, which she sees as killing someone. Thus, she refers to moral values to condemn induced abortion. During an interview at the hospital, a midwife also condemned abortion as an act of killing: "Hum! When I hear abortion I see a life that is taken. Personally I'm not for abortions. If a pregnancy does not put the life of the mother in danger, I do not see why it should be stopped”.

Some other women referred to religious values, like Aïcha, a 19 year-old girl admitted at the hospital after she had had an induced illegal abortion: “I know that abortion is not a good thing. I'm a believer. I was sick and then my boyfriend abused me. When I got pregnant my parents told me to abort.”

Aicha perceived abortion negatively, referring to her religious identity, and she expressed the influence of her parents on her situation, highlighting the fact that she could have not done it if she had a choice. Some women also expressed themselves by evoking the social and health

consequences of abortion. The mother of Fanta, a 19 year-old girl who came to the hospital after an induced illegal abortion, said:

> “Pregnancy can spoil itself naturally. But I know if you induced abortion you will still pay for it. At least you will become sick like my daughter right now. If you do not die also you may not find a husband. Which man would like to have a girl who did abortion?”

Fanta’s mother reveals that abortion is highly stigmatized, associated not just with a risk to life and with economic hardship, but also with ruining a woman’s future chances to get married. This perception of abortion was also expressed by a nurse during an interview:

> "Abortion is not a good thing, because there are too many risks. The biggest risk is death. The smallest risk is hysterectomy… When you are young and you undergo a hysterectomy, it is forever. To have a husband becomes difficult. You will spend your time getting married and getting divorced because you cannot give birth. After that they will go to marabous (traditional healer) and annoying doctors until one discovers that they did an abortion that resulted in a hysterectomy. Thirdly, there are infections that can also lead to secondary infertility. And then you have problems with your God. It is said to give life but not to kill”.

This issue that an abortion can ruin a woman’s marriage ability is also raised by health care providers as threats to fertility following induced abortion. This shows that the negative perception of abortion concerns not just the moral condemnation associated with the abortion itself, but also its negative effects on women’s fertility and marriage ability. Even if some other caregivers perceived abortion through its medical definition, which distinguishes spontaneous abortion from induced abortion, the quote above shows that some caregivers perceive abortion not only as a medical phenomenon, but also as a social phenomenon.

4-2-2-Perceptions of PAC

Health care providers primarily perceive PAC in its therapeutic and its preventative dimensions (prevention of infection and prevention of unwanted pregnancy), as underlined by a medical student I interviewed:

> “By PAC, I see the prevention of infection, and counseling. The counseling will prevent the woman from having another abortion. If it is a spontaneous abortion, we should look for the cause so that if there are additional tests that need to be done after

the treatment we do it. In the case of induced abortions counseling must be done to provide a contraceptive method, to prevent another pregnancy".

This quote seems to highlight the fact that the management of spontaneous abortion can differ from the management of induced abortion. While the management of spontaneous abortion is focused on looking for the etiology of the abortion, the management of induced abortion is focused on the prevention of another abortion through counseling in FP.

PAC is also perceived as an act of saving and maintaining the life of the patient. An interview with a midwife highlights this issue:

> "There is everything from the terminology PAC! That means there is already abortion and then the women need to be treated. Well, it means that we must take care of a woman who has had an abortion so that she is alive and she is healthy! Stay alive, yes, but also healthy to avoid any complications that may occur after the abortion. And these complications are also numerous. So we provide the emergency care to keep the patient in good health and to avoid any further complications."

The idea of "saving" and "maintaining" the life expressed in this quote suggests that PAC is always dealing with emergencies. The aim of PAC is seen to be not only to save the life of a woman, but also to serve as a moralizing function and a warning against the dangers of abortion, as expressed by a nurse involved in providing PAC:

> "I am against induced abortion. But if you are a health worker and you meet someone who life is in danger, you have to help him even if it an illegal abortion. Now when the person survives it will serve as a moral for the other girls who are doing it. One day we received a girl who came after an abortion. She had a uterine perforation. She had no money for the surgery. I talked to my colleagues and they treated her without asking for money…you cannot, see someone suffering and then you close your eyes."

This quote expresses the idea that a health care provider may feel uncomfortable providing PAC to a woman who has had an induced abortion. But at the same time, professional considerations often come to supersede moral considerations. This apparent discrepancy is often justified by the fact that a woman who nearly dies after an induced abortion – but survives – becomes a living warning to other women to avoid the same risk.

Although many health care providers equated PAC narrowly with treating abortion complications and incomplete abortions with MVA, others situated PAC within a more comprehensive continuum of care. As shown by a gynecologist during an interview:

> "First is the management of emergency, secondly it is the counseling and thirdly it is the family planning. That was the three components of the initial concept, but then we

added two elements to bring it to five, One the management of complications, two the family planning, three the counseling, four the links with other reproductive health services and five the links with the community...”

Here PAC is considered as a whole concept taking into consideration health- and social aspects of the care. How do women and their relatives understand PAC?

Some women reduce PAC to MVA; and perceive MVA as an act of abortion. This is typical for women admitted after a spontaneous abortion, like Zara, quoted above. PAC is also sometimes referred to as an act of “washing” the stomach, whether the incomplete abortion it is used to treat was spontaneous or induced. As Aïcha, a 19 year-old woman hospitalized for induced abortion, put it: "I knew that if I came to the hospital they will wash my stomach. I was afraid of the washing because I thought that it was going to hurt me”. Marie, who was admitted after a spontaneous abortion, similarly said: “When I was coming here I knew that the pregnancy was already spoiled. I knew that was going to wash my stomach”.

This perception of PAC as an act of washing the stomach is reinforced by the way health care providers explain MVA to women in their local language. I observed that some health care providers tell women who are about the undergo MVA “ton napeka pugaa,” which in mooré means “we will wash your stomach.” The expression “ton nafonga pugaa”, which means we will do an aspiration, is rarely used. The expression “wash the stomach” is often used as a euphemism, especially when they talk to a woman who lost her pregnancy spontaneously.

Women’s perceptions of PAC can have an influence on their care-seeking behavior. From their homes to the different health centers, from these health centers to the hospital, and inside the hospital from one department to another, they follow a complex therapeutic itinerary in their experience after an abortion.

4-2-3-Therapeutic trajectories

According to the health care providers, they receive two types of patients: those referred from other health centers (public and private) around the city of Ouagadougou, and those coming directly from home. Once a woman enters in the Department of Gynecology and Obstetrics Care for PAC, she is admitted in the delivery room for medical examination. A medical student will write her medical records. When she presents with an incomplete abortion

requiring MVA, she is taken to the MVA room for an aspiration. MVA is usually performed by a midwife. However, when midwives are not available, the gynecologist-obstetricians may perform the procedure. In cases of incomplete abortion with other complications, such as anemia, bleeding or infection, the woman is stabilized before the aspiration. If the health care providers notice that a woman presents with a uterine perforation after admission to the Department of Gynecology and Obstetrics Care, she is taken to the surgery for operation. After MVA or surgery, and before being discharged, the woman is referred to the person responsible for MVA to receive counseling in the use of contraception. In the event that a patient has a renal complication after an abortion, she is transferred in the Department of Nephrology. She is transferred to the department of Internal Medicine if she presents a complication like peritonitis. The Department of Medical Emergencies also refers women presenting post-abortion complications to the Department of Gynecology and Obstetrics Care. For example, from her home, Tina was admitted to a medical center. From this medical center, she was referred to the Department of Gynecology and Obstetrics Care. Inside the hospital, she was referred from the department of Gynecology and Obstetrics Care to the Department of Internal Medicine; inside the Department of Internal Medicine, from the unit of emergency care to the unit of surgery B. She went from this unit to her home and from her home to the unit of emergency care inside the Department of Internal Medicine, before she died.

This description of the therapeutic itinerary of women illustrates a considerable and complex movement of women from one health center to another. This does not mean that women and/or their relatives do not have room for maneuver in the use of health care services. Indeed women and their relatives also play a role in the decision to seek care. That tends to make the supply of PAC a complex phenomenon, in which the perception of different actors and social 'norms" play an important role in access to care after an abortion.

4-3- Delays in care-seeking: PAC as a last resort

According to health care providers, women delay going to the hospital to seek care after an abortion, often going only after the onset of complication. This is especially true for women who terminate their pregnancy. A medical student raised this issue during an interview:

> "The ladies when they start bleeding they come and it is spontaneous abortion. While those who induced the abortion stay at home even if they do not feel well. They often come with complications. It's rare that they come at the stage of bleeding. Very often they arrive at the stage of complications!"

These comments show that the time frame for use of PAC services differs depending on whether the woman has had an induced abortion or a spontaneous abortion. In general, women with spontaneous abortions carry a wanted pregnancy, while cases of induced abortions seem to be a reaction to an unwanted pregnancy. Usually, when a pregnancy is wanted, women are monitored by a health care provider through antenatal care. They are referred immediately when problems occur during medical monitoring of the pregnancy. A midwife stated that reality during an interview:

> "Women do not come early at the hospital. They only come when they see that they have no choice. Those monitored by a doctor will at least come early because the doctor will refer them. But girls who have induced illegal abortions come when they do not fell well at all. They come with bleeding or with something rotten inside their uterus."

This midwife recognized that women who have induced an illegal abortion seek PAC only as a last resort. However, the case of Zara challenges this point of view, as Zara delayed going at the hospital even though she had a spontaneous abortion. As shown from her comments:

> "I started to bleed on Friday. I went to one private hospital where the caregivers told me that maybe I have a problem with my pregnancy. Later on an extra confirmed that. I thought the bleeding would stop because some people say that there are women who continue to see their menstruation even when they are pregnant. On Tuesday I decided to come here (Yalgado Hospital) because I was not feeling well at all. The bleeding had increased."

Zara's experience shows that popular beliefs around pregnancy or hoping that an ongoing abortion will stop can bring women with spontaneous abortion to delay going to the hospital. Thus, the issue of delays to seeking care seems to be more related to the motivation than to the type of abortion. While women with spontaneous abortion may delay going to the hospital even after a referral, hoping to keep their pregnancy, women with induced abortion delay going to the hospital for several reasons. Why do women who have had an induced abortion seek care only as a last resort? When talking about her situation, Aïcha stated:

> "I was pregnant for almost two months and a half. Tomorrow, it was going to be three months. I wanted to keep my pregnancy but I was scared also because of my school. I have a friend who showed me a drug to buy for an abortion. I bought the drug with a street seller for 2,000 CFA Franc. The person told me 20,000 CFA Franc. But I told him that I do not have money and then he gave me four pills for 2,000 CFA Franc. When I took the tablets, after four days people could not approach me because I

smelled bad. When I sat down and then I dropped my head I felt a bad smell. When I belched it smelled bad. My parents asked me many questions and they knew after that I was pregnant. My father brought me to one of his friends to open my cervix. When they opened the cervix, the fetus was already dead. I felt an immense pain and could not even walk anymore because of the injection they did to me. My mother massaged my feet with warm water but I still I was not feeling well. We decided to call my father and explain, because he had travelled. He referred us to his friend who told us to come here (to the hospital)."

These comments show that a girl can have an induced abortion and benefit from the support of her parents. In the framework of the attitude to seeking care, priority is given to a social network, through a close friend in a "private clinic". Formal structures are used when the social network fails to deal with complications. So, there is an attempt to manage the complications post abortion "privately" before seeking help from public and official services.

While some girls benefit from the support of their parents, other girls find it very difficult to inform their parents about their situation because of fear that they will be reprimanded or expelled from home – as expressed by Fanta, who arrived at the hospital in poor health after an induced abortion:

"I had a boyfriend who had promised to marry me. We were together for eight months before I realized that I was pregnant. The pregnancy was two months. When I informed him that I was pregnant he disappeared and came back to me a week after with 20,000 CFA Franc and convinced me to do an abortion. I agreed because I was afraid of the reaction of my father. I talked to a friend about my problem. She already had an abortion. She brought me to an abortionist. When we arrived there we found eight girls also waiting to have an abortion. When it came to my turn I do not know what happened because they gave me an injection and I slept. When I woke up, I bled a lot and I had pain in the stomach. I remained lying at home for a week. When my father asked me what was going on I just told him I was sick. I could not look after my young brother (a baby) because I stopped my job to take care of him so that my mother can go to work. After few days I decided to tell the truth to my mother. We went to Paul VI (medical center). From Paul VI we came here".

The fear of a bad reaction from her parents at the announcement of the pregnancy and abortion led Fanta to hide her health problems after the abortion. Her parents were finally informed when she started to feel really ill. In other cases, too, the women's relatives only discovered their health problems after an induced abortion once they were already

complicated, which is why they often arrived at the hospital in a poor state of health, like Fanta. Once at the hospital, the access to care remains a challenge.

Accessing care

Girls and their relatives who support them often have a modest economic status, and are unable to cope with all the expenses related to PAC. As the sister of Sita, a 17 year-old girl, explained during an informal interview:

> "We arrived here three days ago and we have nothing to buy drugs. She is a student. I also do not have job. And you see that my mother is old. If it was not the lack of money maybe actually she would have felt better. Actually we have to wait until we receive some help from people".

From such comments, women who have financial difficulties cannot count on themselves to get treatment, and expect help from elsewhere (social services inside the hospital, friends, neighbors, etc.). Health care providers recognize the financial barriers to PAC. A gynecologist highlighted this issue by explaining that "MVA is subsidized, and costs 3, 600 CFA Franc. But we have destitute women who cannot even pay for that."

This phrasing underlines the limitation of the subsidy for PAC. When experiencing disease, women often seek support from their relatives in order to deal with the potential money problems they may face during their stay in health care facilities. However, getting support from their relatives may depend on the nature of their disease. It has been reported by women and their relatives that women who face financial difficulties in buying prescriptions will find a lack of support from their social network especially if they are admitted for an induced abortion. As Sita's sister highlighted: "My mother was with her at health center of our village. When the nurse decided to send her here my mother decided to seek help from people. Nobody came except me. You know men do not like to get involved in these things".

Sita's sister is not only raising the issue of the poor support they have from relatives, but also highlighting the fact that men do not like to be involved in supporting a girl who had an induced abortion. Even if this point of view seems to be a reality, the experience of Aicha nuances it a bit, as her father was actively involved in supporting her. He, however, explained how he could not get support from his brother to handle Aicha's abortion-related complication: "The only problem is when she started to suffer I was not around. So I called my brother to come and help them to buy prescriptions until I get there. He just came to insult them and did not pay anything…"

The insults by Aisha's uncle appear to be directly related to the fact that she had had an abortion. He refused to be "involved" in an act that he condemns. Both Sita and Aïcha's experiences show that the non-involvement of relatives in the care for women who have had induced abortion is not merely a gender issue, but rather raises questions about the link between the relatives' attitudes and social and moral norms, as well as stigma. The case of Tina also showed how her sister could not get any support from their neighbor and a social association of citizens from their country. The social stigma and lack of money reinforce one another, since women who have had induced abortions are unable to benefit from family support that is available for women suffering from a less stigmatizing health issue, including spontaneous abortion. In contrast to women presenting for PAC after induced abortion, Zara, who was admitted for spontaneous abortion, was surrounded by her relatives – her husband, her sister-in-law, and her husband - and all of them were supporting her morally and financially.

To avoid the kind of experience faced by Sita and Aïcha, some girls come alone to the hospital for PAC. According to health care providers, such women often experience delays in getting access to care once in the hospital. As one midwife explained:

> "There are women coming alone. They cannot buy drug for their treatment not because they do not have money. They do have money tied to their loincloth but they do not have someone to go and to buy drug or to do their medicals exams for them. That is a problem because they do not get care in time".

This comment shows that once hospitalized, a PAC patient needs someone to do some exams for her, or to buy drugs for her care. So going alone to the hospital can contribute to delaying care for women.

In-depth interviews also revealed that some women pass through several health facilities before arriving at the hospital because they do not want to reveal the true story about their abortions. They often arrive already destitute because of the expenditure incurred in other care centers. Therese's mother explained how Therese's complex care-seeking trajectory following an induced abortion resulted in very high health care expenditure:

> "At first she said she had malaria. We tried to treat malaria for about 20 days without any success. I decided to take her to the medical center. At the medical center we spent four days before they decided to send us to the hospital, to the Department of Medical Emergency (Yalgado hospital). We spent five days there before they realized that she had had an abortion and they sent us here (Department of Gynecology and Obstetrics

Care). I spent more than 100, 000 CFA Franc before arriving here. I borrowed 50,000 CFA Franc from a friend….My uncle also helped us pay for some drugs. Otherwise it is not easy".

Therese's mother's account shows how girls can use silence, or "lie" about their health condition, in order to protect themselves against the risk of abortion-related stigma from their family and health care providers. This attitude leads to a complex therapeutic route, and a lot of expense, due to the cost of different treatments.

This section has shown how financial constraints and lack of social support can contribute to delays in access to PAC. An unwanted pregnancy can mean an uncertain future for girls. As a solution they tend to resort to abortion, which is generally subject to social disapproval. Silence and/or disclosure about an induced abortion can considerably influence their medical support. In general, admitting to an induced abortion can affect the quality of social relations, and lead to a lack of solidarity vis-à-vis girls who have had such an abortion. Thus, the use of PAC services is delayed by the management of other risks, such as stigma. As a consequence, women often arrive at the hospital in a poor health condition. How is the management of their health problems organized in their relations with health care providers?

4-4-The management of PAC and the therapeutic relation between health care providers and women

According to health care providers, girls coming in after an induced illegal abortion are among the most difficult patients, because they do not want to cooperate. As one gynecologist put it:

"The girls come after having induced illegal abortion. But they will never tell you that they tried an abortion. I received several times girls saying "it has been a couple of day I haven't seen my menstruation" "I am bleeding since two days"! You do good interrogation to find out what is going on but they will never admit the truth. They are the most difficult patient we have."

The same issue regarding the non-cooperation of women was highlighted by another gynecologist:

"I was coming every day to visit her and I was taking care of her. One day I came and I found her bed cleaned! I was told she fled with her mother. After few days I have seen them hospitalized. Her mother told me later she thought that she was going to feel well once at home. She is in connivance with her daughter. First she said the girl was

her co-wife now she is saying she is her daughter. They gave us the brush-off all the time. If you are a patient whatever you say it is for your own good. You can give us brush-off but the final result depends on you".

The issue reported here shows how concealment as a coping strategy against the risk of stigmatization is developed by women and their relatives in their interaction with health care providers. These highlight how patients' cooperation can determine their healing or not. A medical student similarly explained how the non-cooperation of patients can have an impact on the treatment: "We have uncooperative patient. In that case you can establish a vague diagnosis. So if your diagnosis is vague your treatment will also be vague"

The comments of the health care providers indicate that the more uncooperative the patient, the more difficult it is to establish a "perfect" diagnosis. Furthermore, observations conducted at the hospital show that the organizational system of PAC may contribute to revealing the secret regarding illegal abortion, and thereby expose women to stigmatization. Indeed, I observed that medical records are differentiated by color, depending on the complication presented by the patient. A green file is used for women with "gynecological" complications. Women admitted for PAC were recorded in the green medical record. Being a patient at the hospital with a green medical record already gives an idea of what kind of patient you are: A patient with an early termination of pregnancy, abortion in progress, or a disease of early pregnancy. Even without seeing the contents of a medical record, some health care providers can guess the reason for a patient's referral simply by noting the color of her record. As stated by a midwife during an informal discussion: "If you see a green medical record bedside a young girl, there's a good chance that she had an induced illegal abortion".

This statement shows how the identification of patients through their medical record can contribute to the stigmatization of patients who are seeking PAC after an induced abortion. Women are often designated by the term "APC" (Illegal induced abortion), or according to the therapeutic treatment they should receive: "there is an AMIU" **(**MVA). This happens when the patient is to be transferred from the hands of one health care provider to another. When a woman is designated by "AMIU", the other health care providers are curious to know if it is an "APC" or not – whether it is an induced abortion. The use of these expressions also contributes to the disclosure of an induced illegal abortion, and exposes women to stigmatization. For example, the lack of compassion from some health care providers is a problem in the relationship between health care providers and patients who come in after an

induced illegal abortion. This is lamented by other health care providers – as stated by a gynecologist:

> "When we receive PAC patients we do our best to avoid judging them because we are here to provide care. But I admit that sometimes people say to women:"you deserve it". There is a lack of compassion! It is sad but it is a reality we are living now. So I can say that this behavior from health care providers is even deplorable!"

Some women explicitly mentioned their fear of health care providers when explaining their actions. For example, the mother of Fanta, who was hospitalized after an induced illegal abortion, said she escaped (or defaulted) from the hospital with her daughter when she had no money, because she did not expect to receive any support from health care providers since her daughter had had an illegal abortion. However, they were obliged to come to the hospital when the girl's health deteriorated.

As this section has shown, collaboration between health care providers and women is essential in the management of PAC. The secrecy around an act of abortion negatively affects the relationship between women and health care providers. According to health care providers, this has clinical implications for the quality of care by contributing to difficulties in assigning a proper diagnosis. Furthermore, my observations have shown that the organizational system of PAC can contribute to the construction of stigma and discrimination in the hospital setting.

4-5-Physical and equipment constraints on access to PAC and their relation to the cost of treatment

The non-availability of health care services offering PAC in rural areas was also mentioned by the women as one of the difficulties they face when seeking PAC. Indeed, according to some of them, the non-availability of services in rural areas increases the cost of the treatment because of the cost of transportation. Marie, for example, a PAC patient admitted to the hospital after a spontaneous abortion, had travelled 130 km from her village to Yalgado hospital after being referred. She rented a car for 10, 000 CFA Franc, and had spent a lot of money buying drugs.

Marie's experience shows the way in which financial and physical constraints on access to PAC reinforce each other. Women living in an area where PAC services are not available pay more money to receive PAC. Once at the hospital, the quality of their support remains limited due to poor equipment, both for them and for women who live close to the facility.

Indeed the problem of equipment has been said by health care providers to not only worsen the difficult conditions under which they work, but also to illustrate the impact of that condition on the quality of care. One midwife explained that the frequent shortage in lubricant gel, for example, makes MVA a painful procedure for women.

When talking about MVA, health care providers pointed out the problem of additional payments that women are obliged to make due to shortages of some of the drugs that are supposed to be included in the MVA kits. As stated by a midwife:

"The kit is always incomplete! Women are obliged to pay for drugs which are lacking. They will take some time to find the money and that delays the treatment."

The limitation of the government subsidy, which is supposed to cover the cost of MVA, is revealed by the fact that women continue to pay too much money to receive MVA:

> "Hum! The subsidy does not solve the problem of the cost. Well, women pay at least 3, 600 FCFA Franc for the kit. There are gloves she must buy at about 3000 FCFA Franc. Additional tests that she will do about 4000 FCFA Franc. In any case women pay a minimum of 8000 FCFA Franc in addition to the subsidy.

As we can see from this comment, some tests ordered as part of the management of PAC may generate indirect payments not covered by the subsidy. In such a context, health care providers tend to take on the role of drugs providers, essentially opening the door for informal payments. Indeed, some women were victims of informal payments. Zara, for example, was asked to give 6,000 FCFA Franc after she got discharged. Surprised by this demand, she asked the caregivers to give her a receipt for her payment. She started to argue with the caregivers because they were saying to her that they used their own drugs to treat her, and she was supposed to refund the money. Finally, the caregivers resigned themselves to letting her go, because the discussion took on a serious tone. She later told me that she had been suspecting them of taking money from her since her admission, and had eventually decided to protest.

This section has shown how physical constraints, constraints related to the equipment, and incomplete MVA kits can increase the financial cost of PAC, not least because women are often confronted with demands for unexpected and informal payments. For example, after one MVA, a girl asked a health care provider how much she should pay for her treatment. The health care provider asked me if I was the one who was supposed to pay for her, because of my research grant. I told him that my project is only about research, and did not have money to support the treatment of patients. He hesitated, and asked for 10,000 CFA Franc from the girl.

4-6- The supply of comprehensive PAC for women: myth or reality?

According to health care providers, women's behavior after being treated with MVA can lead to therapeutic disruptions in the supply of PAC. Indeed, according to a midwife, it is common that women escape from the hospital after the MVA before they have completed their treatment regiment: “Once you have finished doing an MVA, if you do not quickly give advice to the woman, once you move a little she will disappear, unless she has other health problems”.

Women expressed two main reasons for such quick departure following MVA: either they escaped because they were afraid to deal with other expenses after MVA, or they just went home, simply in the belief that the treatment was completed – as many of them perceive PAC as an act of "washing the stomach". So, once the stomach is “clean”, they should go. According to the health care providers, however, PAC should not stop with MVA; crucially, women who have undergone PAC should be offered FP services. In practice, following up women after MVA involves a number of difficulties beyond the women defecting. As explained by one midwife:

> “For example in the treatment protocol after each uterine evacuation the patient should be offered a contraceptive method. But the problem is that we do not have the different contraception. So we must always direct them elsewhere. Because of that we lose many patients. Another thing, when we convene the patients for the follow up after seven days, there are many of them who do not return. Maybe only 10% will return”.

This comment points to the fact that the unavailability of contraceptives in the place where women receive counseling after MVA limits their adoption of FP after an abortion. The lack of adoption of family planning methods after an abortion may also be due to the lack of proper information about the use of FP during PAC. Indeed, in the MVA room, one can observe a poster on FP on the wall. This information seemed to be enough for some health care workers, who did not care about the counseling on FP. Indeed, one day I was negotiating an interview with a girl who was leaving the hospital after discharge. As she did not have the time, I told her that if she came back after seven days, we could talk. She was surprised to hear that from me, and asked me why she should come back. So I told her that some women I had met had come back after seven days, and maybe she should ask the health care workers to learn more about it. Once she went to them, they harshly told her that the information regarding the FP was written in her medical record; because she was uneducated and illiterate, the girl could not read it.

Health care providers also pointed out the fact that, in practice, PAC is often reduced to the management of emergencies only. As stated by a gynecologist:

> "… I feel that our PAC's supply is limited to the management of emergencies. After PAC we don't have time see patients again yet this is the only chance we have to catch these people and put them under contraception because each case of induced abortion illegal is a failure of family planning."

This gynecologist was critical of the concept of PAC, and of how it is implemented in practice. For him, the supply of PAC at the Department of Gynecology and Obstetrics Care stops at emergency treatment, while it is supposed to prevent future unwanted pregnancies and illegal abortions. PAC does not only mean MVA. Furthermore, some women admitted at the hospital presented with post-abortion complications which needed to be treated beyond the Department of Gynecology and Obstetrics Care.

Women are often admitted to the Department of Internal Medicine for peritonitis, perforation of the uterus, while they are admitted to Nephrology for renal problems. According to health care providers in these two departments, not only is the cost of treatment in their service very high, but it is also out of reach of patients, and unsubsidized. As pointed out by a nurse from the Department of Internal Medicine and a nurse from the Department of Nephrology respectively:

> "Women who do not have money for their treatment it is a big problem. But those who have their money they pay their kits because the kit for surgery here is not subsidized. It costs 63,000 CFA Franc here while it costs 11,000CFA Franc at the maternity service. So there is a big difference...In the year we can receive twenty patients and at least five will die."

Another nurse explained that the minimum cost a PAC patient will pay is 80,000 CFA Francs. "We receive about 5 patients in the month and at least one will die."

These comments highlight the complexity of PAC, which although often equated with MVA, in reality involves several departments of care. The case of Tina is a good example for this issue, as she died when seeking PAC after being referred to another department of care, and was lacking adequate support. Indeed, this show cases the limits of Burkina Faso's PAC policy, which focuses its effort only on the departments of gynecology and obstetrics care at the hospitals, while PAC patients admitted to other departments of care are dying because of limited access to care due to the cost of the treatment.

Women's chosen behavior after the MVA, the poor supply of FP, PAC focused only on emergency treatment, and the limits of the policy for subsidizing PAC are elements that show the fragility of the concept of PAC. These elements underline the society's interest in taking a collective responsibility to make this concept a reality.

Chapter 5: Implications and conclusions of the study

The aim of this study was to explore how women negotiate their access to hospital care after an abortion in Burkina Faso. In order to understand the factors that can influence women's access to PAC, I have taken an ethnographic approach. The ethnographic approach allowed me to include many perspectives in the data collection, in order to have a holistic view of PAC in one hospital in Burkina Faso. The use of observations, interviews, and informal discussions, involving women, their relatives, and health care providers, has been useful for understanding the problems of PAC. Furthermore, strength of ethnographic methods is that they lead to an in-depth, descriptive account of a phenomenon under study, and deep insight into specific case study contexts (Walker, 2011). For example, the case of Tina highlights deep social and structural challenges and issues related to PAC in the setting of Burkina Faso. However, the ethnographic approach also has some weaknesses that need to be exposed. Importantly, my presence as a researcher doing participant observation may have influenced facts on the ground in my study sites considerably. For example, the kindness that some health care providers showed Tina may be due to the fact that I was doing my research on her case, and I was close to her. Also, by focusing my observation on a selection of cases, I may have missed other relevant findings. However, I could have not been in many places at the same time.

The different interactions I had with the health care providers, the women, and their relatives placed me in multiple and sometimes conflicting roles – including not only the researcher role, but also a translator role, and a role as a guide through the care-seeking trajectory. I was in a kind of “give and take” relationship with my research participants, which often raised ethical dilemmas. Indeed, during my field work, I faced several situations where I asked myself various questions: what should I do? What should be the limits of my actions? During my interactions with some of my interlocutors, there were certain situations that required me to take a particularly critical stance, and to distance myself from their needs and desires. Two examples illustrate these ethical dilemmas:

In the first example, one day, the caregivers simply told me that there was a case of abortion which would interest me. They suggested that I participate in the examination of the patient, in order to collect information both for them and for me. They were sure that the patient once out of the room would not want to talk to me. However, they also expressed that they needed to know more about the history of her abortion, in order to establish their diagnosis. Accordingly, I went into the delivery room, where I was confronted with a sick woman in a

situation of little privacy. Ethical imperatives took precedence over my desire to get potentially useful data for my research. I refused to go and talk to the lady, because I am not a health professional, and I would be breaking my ethical requirements as someone who is not part of the service. This refusal on my part changed somewhat the nature of my relationship with the caregivers of this department of care. So, I changed my place of observation, extending my stay in the other departments of care, before returning to the previous department of care.

In the second example, caregivers from another department of care asked me to contact one of their colleagues, who performed illegal induced abortions in another health center. Seizing the opportunity of the fact that I was working on the issue of abortion, they wanted to warn him that many women who were hospitalized for post abortion complications reported having used his services (some of them died). The case had taken an ethical and legal turn. For me, any involvement in this case was contrary to the objectives of my research, which were to collect data on PAC. I refused to assume the task they were giving me – a task which certainly could have been a "noble act", as it could have contributed to stopping a "criminal". However, this task was clearly at odds with the objectivity of my research, and would conflict with my position as a social/health science researcher.

My presence at the hospital during my field work may have contributed to change the course of some events. For example, I paid for a drug for one woman. What would have happened if I was not present? In another case, caregivers changed their attitude towards a woman because of my presence. However, while I did influence the course of events, my presence could not have prevented one of my participants from dying.

Indeed, during my data collection, I followed Tina's case, and I witnessed her death. It was a complex case, which gave an impression of the experiences that some women may face when seeking hospital care after an illegal abortion. During the observation of this case, I constantly interacted with the woman, her relative, and her caregivers. Because caregivers often needed a translator who spoke her language, my presence became virtually indispensable for her. In addition to this, she became accustomed to me, and appreciated my presence at her side. Despite my contributions – purchasing some medicines for her, buying food for her, and translating for her – my presence could not prevent her death, and I found myself in an uncomfortable situation. Furthermore, while this case interested me because of its relevance

for my research, my indirect involvement in the management of Tina's case raises an ethical question that deserves reflection.

Could I have I have prevented Tina's death? Most likely no. Moreover, my part in the management of her case did not in any way contribute to her death. Instead, my part demonstrated how a patient lacking social support could benefit from informal support when seeking hospital care. In my role as a person of support for the woman, as well as in my role as a researcher, I was thus trying to understand the various events and facts that could shed light on the barriers that might confront women during their hospitalization after an abortion. The time I spent with her allowed me to be immersed in all these realities before her death. Thus, for documenting the limits of the concept of PAC, this case would have been a "good" case even if she had not died. However, I told myself that I could not abandon her once I had gotten sufficient information illuminate my research objectives. The fact that I extended the duration of my fieldwork, in order to spend time with her and to support her as best I could, led me to be a witness to her death. Based on the emotions that I felt after her death, I told myself that my thesis could be achieved without the presentation of this case. But then I found myself confronted with an issue that can also be considered an ethical research issue: In an act of research, I had witnessed an event which, when presented as research, could contribute to making others look again at the issue of PAC in Burkina Faso, and improve the supply of services. Thus, I had to choose between the concern to conceal this story, where my personal involvement as an observer and a witness would be questioned and my concern to produce data which accurately showed a woman's experience after an abortion. I chose the latter.

Ultimately, the findings of this study show that the experience of the PAC is both a social and a medical experience, involving the several and overlapping perceptions and practices of the women, their relatives, and health care providers. These perceptions and practices are constructed by social norms, and by structural and organizational constraints regarding abortion and the provision of PAC. As a consequence, women’s access to care is often delayed, and they are also often the victims of a poor quality of care, including discrimination from health care providers who are opposed to abortion.

This study shows how perceptions of abortion and PAC are rooted in social representations that may have repercussions in practices. In fact moral, religious, social and professional values constantly influenced the perceptions of different people, which, in turn, played out in

their attitudes and practices. This study shows that post-abortion experiences are socially constructed, because individuals' perceptions – both those of patients and providers – shape their way of dealing with illness (Larsen, 2009). Thus, the attitudes of fear leading girls to attempt dealing with abortion complications in their social environment before seeking hospital care, show how delay in access to PAC services happens. This issue has been also found in a study in Zimbabwe, where the fear of the parents' reaction to induced abortion contributes to delaying girls' access to care (Seterrgren et al., 2000). While some authors believe that improving accessibility of post-abortion services throughout the public sector would save lives (Gebreselassie et al, 2010), this study showed that the use of PAC services is not "easy" for some women. Women's encounters with PAC can be thought of in terms risk management, maneuvering between the social risk of revealing an abortion that would be condemned by their relatives, and the health risk of worsening post-abortion complications. Women and girls often try to manage social risk, in some cases with the support of their relatives, with the consequence that the use of available PAC services does not come first.

The study's findings also emphasize the importance of women's relatives in negotiating their access to medical care: By dealing with financial barriers, purchasing medicines, helping to access medical examinations, and providing nursing care and food to hospitalized women, women's relatives are central actors in the provision of PAC. Fathers, husbands, sisters, and mothers may all intervene in the process of PAC. For example, Tina's case, relayed above, shows how her sister fought for her survival, even though Tina eventually died. By contrast, some family members' refusal to become involved in the support of women who have had an induced abortion shows how social stigma can constrain access to PAC. A study in Uganda showed that women in need of financial support after an induced abortion can delay seeking abortion care because men refuse to be involved in their support because of social, religious, cultural, and legal norms (Moore et al., 2011). This study supports, but also nuances, these findings from Uganda, showing that beyond the gender issues and moral considerations, the relational aspects of women's care-seeking are also very important. Tina's case highlights that the ability benefit from the support of relatives and neighbors and other networks, such as religious or civic associations, may be linked to the nature of the relationship that existed before the onset of disease. It is clear that women who face financial barriers to accessing care always need support from their relatives or from a third party, all the more since public social protection and welfare arrangement remains weak or even nonexistent in Burkina Faso (Storeng et al, 2012).

I would argue that abortion-related stigma can be created during hospital care. The five characteristics of the production of stigma proposed by Link et al. (2006) were all in evidence in the provision of PAC at the hospital where I conducted participant observation: The identification of differences, the production of stereotypes, the separation between "them" and "us", discrimination, and the exercise of power (in the power of the caregivers over the patients). Indeed, I found that the organizational system of care at the hospital, and the formulation of the medical diagnosis for some patients admitted after an induced abortion, marked them with a distinctive and visible sign – in the form of medical records identifiable as relating to induced abortion – that exposed them to stigma and discrimination. These findings modify the position that abortion stigma may differ from stigma associated with other diseases because of the lack of visible markings (Kumar et al.; 2009). Indeed, the standards established in a structured environment like the hospital – such as the use of medical records of an identifiable color – contribute to the disclosure of the "secret" of an induced abortion, exposing women to stigma. In addition, the unequal treatment received by women after an induced abortion and after a diagnosis of spontaneous abortion (e.g. the lack of compassion following an induced abortion), shows that health care providers can import their social, religious, and cultural values when performing their professional activities (Ouattara et al., 2009). This implies that the risk of exposure to stigma that women experience in their social environments is reproduced in the hospital setting. For example, in the case of Tina, one of her caregivers was so shocked when Tina openly told him that she had wanted to get rid of her pregnancy that he subsequently abandoned her care. From this example, one can easily understand why some girls refuse to disclose having had an illegal, induced abortion in their interaction with health care providers. The fear of health care providers and the concealment of induced abortion may affect the therapeutic relationship during the provision of PAC at the hospital negatively; a study in Nepal (Puri et al, 2012) also found the same result.

The women's experiences further reveal how physical constraints, constraints related to equipment, and to stock ruptures in MVA kits, can exacerbate the financial cost of PAC – in part by confronting women with unexpected and/or informal payments. The way in which, PAC policy and practice has come to focus only on MVA, and often fails to provide FP advice, highlights the reductionist nature of PAC in Burkina Faso. The same issues have been highlighted by Rawlins (2011) in Nepal.

The cases I have observed can add to existing studies showing how access to safe abortion can be restricted by the law, and menace the health and the life of women (e.g. Singh and al; 2009). This study also highlights the *complexity* of PAC, which involves several departments of care, illustrating the limits of Burkina Faso's PAC policies, which focus their efforts on the Departments of Gynecology and Obstetrics Care at the hospital, and in the maternity unit at the level of Medical Centers and Primary Health Care.

One of the main implications of this narrow focus is that it increases the cost of care for women. In 2006, Burkina Faso adopted a policy to subsidize deliveries and emergency obstetric care (Ridde et al; 2011). In the framework of this policy, MVA should cost 3, 600 F CFA Francs, while surgery within the Department of Gynecology and Obstetrics Care should cost 11,000 F CFA Francs. However, the subsidy does not cover surgery or care provided in other hospital departments. This helps to explain how Tina, for example, spent more than 200, 000 FCFA Francs before she died; she needed more care than MVA, and she needed it provided not only by the Department of Gynecology and Obstetrics Care, but also by the Department of Internal Medicine, where patients do not benefit from the subsidy. My findings point to the limits of the global discourse regarding the scaling up of PAC in order to make them more comprehensive and accessible for women (RamaRao et al, 2011), because this discourse is still focused on obstetrics care services and reproductive health services, while the needs of women after an abortion go beyond these services. This study therefore highlights the need for an integrative response across health care services in the supply of PAC.

Findings from this study cannot be generalized to all health care facilities in Burkina Faso. For example, Yalgado hospital and the primary health centers do not deal with the same type of post-abortion complications. Indeed, the majority of women who participated in this study had post-abortion complications, which are generally treated in referral medical centers such as Yalgado hospital. In addition, this study has shown the problems that PAC patients face in getting access to care once they are transferred to departments of care beyond the Department of Gynecology and Obstetrics Care. So, it would be difficult to generalize my findings to health facilities which do not have the organizational complexity of Yalgado Hospital. However, the results of the study have relevance for other complex structures, such as regional hospitals and medical centers. This relevance includes the findings about the complexity of PAC in the management of women's treatment after an abortion, and about the

non-integration of FP services in the provision of PAC, which can have a negative effect on the use of contraceptive methods after an abortion.

This study is the first study to look at the issue of access to PAC in Burkina Faso since it was introduced in 1998. It used an innovative approach from ethnography to show the holistic dimension of PAC, and explored the involvement of health services other than maternity care services in the supply of PAC.
This study does not aim to provide solutions to the problem of PAC in Burkina Faso. However, it does demonstrate the importance of taking into consideration the complexity of the concept of PAC. Despite the narrow, technical focus of PAC policies, both in Burkina Faso and internationally, this ethnography reveals that, in practice, PAC is a very broad concept that demands a holistic approach.

The study also showed how PAC means dealing with the consequences of unsafe abortion rather than the causes of unsafe abortion, as the preventive dimension of the care policy (i.e. counseling and family planning) does not work at all. It will be relevant to consider this issue when discussing PAC policies. Seeking for PAC can contribute to breaking the secrecy about unwanted pregnancy and induced abortion. This does not necessarily create more openness around abortion, but can rather contribute to exposing women to stigma in their social relationships with their relatives and in their encounters with health care providers. This stigma is reinforced by the organizational system of PAC and the medical discourses during the provision of PAC.

References

1- Ahman E., Dolea C., Shah I. (2000), the global burden of unsafe abortion in the year 2000. http://www.who.int/healthinfo/statistics/bod_abortions.pdf.

2- BAYA B. et *al* (2006), « La mortalité au Burkina Faso », Recensement Général de la Population et de l'Habitation du Burkina Faso.

3- Bedru A. O. and Ruyter K. W (2009), Medical research Ethics-Lesson 5: Risk benefit to participants in research. fronter.uio.no/links/files.phtml (January 2012).

4- Berman S M., Mackay T., Grimes DA., Bikin N. J., deaths from spontaneous abortion in the United States, *Juma,* V 253, No. 21, 3119-3123.

5- Berer M. (2004), Abortion Law, Policy and Practice in Transition, Reproductive Health Matters, Vol. 12, No. 24, pp. 1-8.

6- Bertrand J. T and Escudero G, (2002), compendium d'indicateurs pour l'evaluation des programmes de la Santé de la Reproduction. Manuels MEASURE Evaluation Numéro 6, Volume 2.

7- Boland R., Katzive L., (2008), developments in laws on induced abortion: 1998–2007, *International Family Planning Perspectives, 34(3):110–120,* Guttmacher Institute.

8- -Brewer J.D., (2000), Ethnography, Buckingham: Open University Press, a recent text with discussion of ethnographic analysis.

9- Corbett M R. and Turner K L., (2003). Essential Elements of Post-abortion Care: Origins, Evolution and Future Directions. International Family Planning Perspectives, Vol. 29, No. 3 (Sep., 2003), pp. 106-111Published

10- Creswell J W. (1994), research design: qualitative and quantitative approaches, Sage Publications, 228 pages.

11- De Allegri M., Ridde V., Louis R. V., Sarker M., Tiendrebéogo J., MauriceYé M., et al. (2010), determinants of utilization of maternal care services after the reduction of user fees: A case study from rural Burkina Faso, G Model HEAP-2620; No. of Pages 9, published by Elsevier Ireland Ltd.

12- DeWalt, K. and DeWalt, B. (2002), participant Observation, Pittsburg, Rowman Alttamira.

13- Dieng T., Diadhiou M., Diop J. N., Faye Y., (2008) assessment of progress of the Post-abortion Care initiative in Francophone Africa, FRONTIERS Program. Repport.

14- Dolar D. G. (1997), the experience of abortion: a bibliography essay. *Psychologie in society (PINS), 22, 47-59*.

15- Faùndes and Hardy, (1997), illegal abortion: consequences for women's health and the health care system, Gynaecol Obstet. ;58(1):77-83, Pubmed.

16- Fitzpatrick R., Mary Boulton M. (1994), qualitative methods for assessing health care, qualitative in health care; 3: 107-113.

17- Grimes D. A., Benson J., Singh S., Romero M., Ganatra B. et al (2006), Unsafe abortion: the preventable pandemic, *Lancet*,, 368(9550):1908–1919.

18- Grimes DA. Reducing the complications of unsafe abortion: the role of medical technology. In: Warriner IK, Shah IH (2006) eds. *Preventing unsafe abortion and its consequences. Priorities for research and action.* New York: The Guttmacher Institute, 73–91.

19- -Gebreselassie et al (2010), Caring for women with abortion complications in Ethiopia: National estimates and future implications, *International Perspectives on Sexual and Reproductive Health*, Volume 36,Number 1.

20- Germain A.; Kim T. (1998), expanding access to safe abortion: strategies for Action, International Women's Health Coalition, 44 p.

21- Grisanti A. M. (2000), the abortion dilemma, the Master's Seminary journal 11/2, 169-190, Masters Theological Seminary. Web site: www.tms.edu.

22- Guion L. A. et al, (2012) triangulation: establishing the validity of qualitative studies, university of Florida. https://edis.ifas.ufl.edu/fy394.

23- Haddad L. B. and Nour M. N. (2009), Unsafe Abortion: Unnecessary Maternal Mortality, Rev Obstet Gynecol; 2(2): 122–126 PMC.

24- Henshaw S. K., Adewole I., Singh S., Bankole A., Oye-Adeniran B., Hussain R., (2008), gravité et le coût des complications de l'avortement à risque traités dans les hôpitaux nigérians, perspectives internationales sur le Planning Familial, Volume 34, Numéro 1, Guttmatcher Institute

25- Horsburgh D., (2003), evaluation of qualitative Research, *Journal of Clinical Nursing*; 12: 307–312.

26- Hulington D., and Piet-Pelon J. N., (1999), Post abortion care: lessons from operations research, Population Council, USA.

27- Hunlington D., Mensch B and Toubia N, (1993), a new approach to eliciting information about induced abortion, *Studies in family planning*, Vol. 24, No. 2, pp. 120-124, Population Council.

28- INSD (2008), annuaire statistique du Burkina Faso.

29- INSD (2006), recensement général de la population et de l'habitation de 2006.

30- INSD (1999), annuaire statistique du Burkina Faso.

31- Jagnayak SS (2005), a study on abortion practices in Kerala, Southern Institute for social science research, Trivandrum.

32- Kumar A, Leila H L and Mitchell E M. H., (2009), conceptualizing abortion stigma in *Culture, health and sexuality.* Routledge. Vol. 11, No. 6. P 625-639.

33- Lankoandé J. et al. (1999), la mortalité maternelle chez les adolescentes au CHU de Ouagadougou Revue Med.Brux., n°2, pp. 87-89.

34- Larsen P., the illness experience in Jones & Bartlett Learning,(2009), chronic Illness: Impact and Interventions - 634 pages, http://samples.jbpub.com/9781449649050/99663_CH02_V2xx.pdf.

35- Lester S., (1999), an introduction to phenomenological research. (www.sld.demon.co.uk/resmethy.)

36- Link, B. G. and Phelan J. C., (2006), stigma and its public health implications.*Lancet* 367(9509):528–529.

37- Machado N., Burns T R., (1998), complex social organization: multiple organizing modes, structural incongruence, and mechanisms of integration, Public administration, Public Administration, Volume 76, Issue 2, pages 355–386.

38- Malterud K., (2001), qualitative research: standards, challenges, and guidelines, lancet, moodle.ncku.edu.tw.

39- Marshall M. N., (1996) sampling for qualitative research, Family Practice, Oxford University, Vol. 13, No. 6..

40- Milingos DS, Mathur M, Smith NC, Ashok PW. (2009) Manual vacuum aspiration: a safe alternative for the surgical management of early pregnancy loss. BJOG.116:1268–71.

41- Ministère de la santé du Burkina Faso (2012), Tableau de bord santé 2011.

42- Ministry of health of Burkina Faso (2011) implementing of strategies for reduction of maternal mortality in Burkina Faso.

43- Moore A. N., Jagwe-Wadda G., Bankole A., (2011), men's attitudes about abortion in Uganda, Journal of biosocial science; 43, pp 31-45.

44- Nader L., (2011), ethnography as theory, HAU: Journal of Ethnographic Theory 1 (1): 211–219, University of California, Berkeley.

45- Öhman A., (2005), qualitative methodology for rehabilitation research, *epidemiology and Public Health Research*, J Rehabil Med; 37: 273–280.

46- Ouattara F. et al (2009). Sans un « mari »La nécessité du mariage dans les structures de soins à Ouagadougou (Burkina Faso). Autrepart (52), p. 81-94.

47- PNUD (2010), Rapport sur le développement humain, PNUD, USA.

48- Policy project (2003): Conakry forum on promotion of Family Planning through advocacy and legislative reform. http://www.policyproject.com/pubs/countryreports/Conakry_Summary.pdf.

49- Population Council (1998), recherches opérationnelles sur les soins post-abortum : Progrès et défis , *Compte rendu d'une réunion mondiale,* New York.

50- Porter S, (1991), a participant observation study of power relations between nurses and doctors in a general hospital, *Advanced Nursing, 16*, 728-735.

51- Puri M, Lamichhane P, Harken T, Blum M, Harper CC, Darney PD and Henderson J T, (2012), "sometimes they used to whisper in our ears": health care workers' perceptions of the effects of abortion legalization in Nepal, *BMC Public Health*, 12:297.

52- RamaRao S, Townsend J W, Diop N and Raifman S, (2011), Postabortion Care: Going to Scale, *International Perspectives on Sexual and Reproductive Health,* V 37, No 1.

53- Rasch V. (2011). Unsafe abortion and post abortion care – an overview. Acta Obstetricia et Gynecologica Scandinavica C _ 2011 Nordic Federation of Societies of Obstetrics and Gynecology 90**.** 692–700.

54- Reeves S., Kuper A., Hodges B. D., (2008), qualitative research methodologies: ethnography, BMJ, volume 337: a 1020.

55- Ridde V., Richard F., Bicaba A., Queille L., and Conombo G., (2011), the national subsidy for deliveries and emergency obstetric care in Burkina Faso, *health Policy and Planning* ; 26: ii30–ii40, Published by Oxford University Press in association with The London School of Hygiene and Tropical Medicine.

56- Rossier C, Guiella G, ,Ouédraogo A, Thiéba B, (2006), estimating clandestine abortion with the confidants method—results from Ouagadougou, Burkina Faso, *Social Science & Medicine,* 62, 254–266.

57- Rossier C. (2007) Abortion: an open secret? Abortion and social network involvement in Burkina Faso. Reproductive Health Matters. Vol. 15. No. 30 in *maternal mortality and morbidity: is pregnancy getting safer for women*? pp 230-238. Published by: Reproductive Health Matters (RHM)Stable URL: http://www.jstor.org/stable/.

58- Seale, C. (1999), quality in qualitative research. *Qualitative Inquiry, 5*(4), 465-478.

59- Sedgh G, et al.(2012) Induced abortion: incidence and trends worldwide from 1995 to 2008. *Lancet,* 379:625–632.

60- Sedgh G, Rossier C, Kaboré I, Bankolé A, Mikulich M, (2011), estimating Abortion Incidence in Burkina Faso Using Two Methodologies, *Studies in Family Planning*, Volume 42, Issue 3, pages 147–154.

61- Sedgh G, Henshaw S, Singh S, Ahman E, Shah I, (2007) Induced abortion: estimated rates and trends worldwide, The Lancet, Volume 370, Issue 9595, Pages 1338–1345.

62- Sedgh G et al., legal abortion worldwide in 2008: levels and recent trends, *Perspectives on Sexual and Reproductive Health*, 2011, 43(3):188-198.

63- Settergren S., Mhlanga C, Mpofu J., Ncube D., Woodsong C. et al. (1999), unsafe Abortion and Post abortion Care in Zimbabwe: Community Perspectives, Policy matters, N0.1.

64- Shellenberg K. M. and al. (2011) Social stigma and disclosure about induced abortion: Results from an exploratory study. Global Public Health, 6:sup1, S111-S125.

65- Singh S, (2010), global consequences of unsafe abortion, *Women's Health* 6(6), 849–860, Future Medicine Ltd. Singh S et al.(2009).

66- Singh S et al. (2009), Abortion Worldwide: A Decade of Uneven Progress, New York: Guttmacher Institute.

67- Singh S. (2006), hospital admissions resulting from unsafe abortion: estimates from 13 developing countries. *Lancet*; 368: 1887–92.

68- Solo J, (2000) Easing the pain: pain management in the treatment of in- complete abortion, Reproductive Health Matters, No. 8, pp. 45-51.

69- Storeng K, Drabo S, Fillippi V, (2013), too poor to live? A case study of vulnerability and maternal mortality in Burkina Faso, *Global Health Promotion*, 20: 92-99, SAGE journals.

70- Storeng KT, Drabo S, Ganaba R, Sundby J, Calvert C, Filippi V (2012), Mortality after near-miss obstetric complications in Burkina Faso: medical, social and health-care factors, *Bulletin of the World Health Organization*, 90:418-425C.

71- Stuart M. Berman and al (1985) deaths from spontaneous abortion in the United States. JAMA volume 253, No 21.

72- Tapsoba A. S. Les avortements dans les centres hospitaliers nationaux du Burkina Faso: Evaluation de l'impact d'une prise en charge intégrée pour le traitement des complications. Th. Méd., Ouagadougou, 1999, n°621, p: 88.

73- Thorne S., (2013), data analysis in qualitative research, EBN notebook, Downloaded from ebn.bmj.com on April 3, 2013 - Published by group.bmj.com.

74- UNICEF (2010), Statistics, Burkina Faso,

http://www.unicef.org/french/infobycountry/burkinafaso_statistics.html.

75- Vlassof M. (2006), economic impact of abortion related morbidity and mortality: modeling worldwide estimates, www.realising-rights.org/researchers/Publications/id21H

76- Walker S. (2011), ethnography – informing relevant, effective and sustainable policy interventions, series briefing note 36, City & Guilds Centre for Skills Development, United Kingdom.

77- WHO (2012), safe abortion: technical and policy guidance for health systems – 2nd ed., Geneva: WHO.

78- WHO (2008). Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality. 6th ed. Geneva: WHO.

79- WHO, (2003), safe abortion: Technical and Policy Guidance for Health Systems, Geneva: WHO.

80- WHO (1992), the prevention and management of unsafe abortion: report of a technical working group, Geneva: WHO.

81- World Medical Association (2008), Ethical principles for medical research involving human subjects. The Declaration of Helsinki. http://www.wma.net/en/30publications/10policies/b3/index.html

82- Zucker L. G., (1987), institutional theories of organization, Annual Reviews Sociol 13:443-64 Inc.

Appendix

Interview Guide for women

The interview

Day of the interview:
Hours:
Time of the interview:
Place:
Language of the interview:
Recorder: Yes or No

Socio-demographic characteristics of women

Identification number
Age:
Home (sector or district):
Contact:
Ethnicity:
Religion:
Education:
Marital status:
Occupation:

Women's reproductive history

Number of pregnancies

Number of children living

Number of children dead

Had you had pregnancies which had not come to term? If yes how many? Was it a stillborn or abortions? If abortion, how it happened (to see whether it was induced or spontaneous)

Relation with relatives (spouse/partner, family and in-laws)

What is your relationship with the people with whom you live?

How can you describe your relations with your partner (spouse) or family?

Pregnancy, abortion and PAC

What was your reaction when you knew you were pregnant (expected or not expected to be pregnant)?

Who was (parents, spouse, friend) aware of your pregnancy? If so what was their reaction? If not, why they have not been informed?

How the pregnant was followed?

Did you have some problems (social, financial, health) during pregnancy? What problems? Can you please tell me more about?

The abortion

Can you please tell me more about the condition under which you lost your pregnancy (try to find out if it was spontaneous or induced, to understand the experience of this fact…)?

What was the age of the pregnancy?

When have you decided to seek care? Have you decided to seek care by yourself or it has been decided by someone else? Where have you been first? How did you get to the hospital (reasons, transportation)?

What kind of care have you received (Home and hospital)?

Can you tell me more about the way health worker were behaving toward you?

What are the expanses you have done since you decided to seek care? Who were paying for the prescriptions given during your sickness?

What kind of challenges did you face during your sickness and your hospitalization?

Perception of abortion and PAC

Abortion: what does it mean to you?

What is your perception of abortion?

What was your expectation when you were seeking for care?

Do you think this abortion made or will make some changes (consequences) in your life?

What are your opinions about abortion (to legalize or not)?

Were you expecting some questions I did not ask?

Interview Guide with health workers

The interview
Day of the interview:
Hours:
Time of the interview:
Place:
Language of the interview:
Recorder: Yes or No
Socio-demographic characteristics
Sex:

Ethnicity:
Religion:
Age:

Professional status:

Service:

Professional itinerary

Perception of abortion and PAC

What is your opinion on abortion?

According to you, what are the factors involved in the voluntary interruptions of pregnancy?

Have you ever, in your experience, been dealing with requests for termination of pregnancy?

What were the motivations of these applications?

How do you react to this type of application?

The supply of PAC

What do you understand by PAC?

What happens when a woman arrives after having an abortion (be it spontaneous or induced)?

How can you differentiate a spontaneous abortion from an induced abortion?

Can you tell me something about the cost of PAC? How different payments are done?

Are you facing any kind of challenges in the supply of PAC (relational (women, colleagues), material, organizational…)?

List of figures